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A NOTE
ON SODIUM MORRHUATE IN TUBERCULOSIS.

BY

SIR LEONARD ROGERS, KT., C.I.E., M.D.,
F.R.C.P., F.R.S., LIEUT.-COLONEL I.M.S.

TUBERCULOSIS is the greatest medical problem of the day, being one of the most frequent causes of sickness and death in tropical as well as temperate climates. If anything like a cure for this disease could be discovered, the losses of the great war would be replaced within a very few decades. During the last year I have been working at a new line of treatment of tuberculosis on similar lines to that which has proved of great value in my hands in the case of the other human disease produced by an acid-fast bacillus, namely, leprosy. By a similar process to that by which sodium gynocardate is made from chaulmoogra oil a preparation has been made of the sodium salts of the unsaturated fatty acids of cod-liver oil after extraction by ether. This I have termed "sodium morrhuate."* A 3 per cent. watery solution is sterilized in an autoclave and ½ per cent. carbolic acid added. This may be injected subcutaneously with very little pain, and also intravenously. I had previously shown in 1916[1] that intravenous injections of sodium gynocardate in leprosy produced febrile and local reactions with breaking down of the bacilli and had suggested its trial in tuberculosis as that disease is also produced by an acid-fast bacillus. As, however, in rare cases of leprosy prolonged febrile reactions with temporary exacerbation of the disease may follow sodium gynocardate given intravenously,[2] I hesitated to use it in tuberculosis by that method. Given by the mouth in phthisis some gain in weight only resulted, and it causes painful local induration hypodermically. Several attempts I made to investigate the use of the drug in tubercle infected animals failed for want of a virulent bovine culture. It was in these circumstances that I was led to prepare sodium morrhuate from cod-liver oil. Its subcutaneous injection proved to be nearly painless, and a year's experience has shown it to be of great value in leprosy. This is a most important point, as it proves that there is nothing absolutely specific in the products of chaulmoogra oil in that disease, and supports my view that the sodium salts of the unsaturated fatty acids of these two oils act in some way on the coating of the acid-fast bacilli, that of tuberculosis having been shown to contain palmitic and other unsaturated fatty acids. During the past year sodium morrhuate has also been used with very promising results in tuberculosis by several careful observers to whom I have supplied it, and morphological changes have been noted in the tubercle bacilli in the sputum. A wide field of investigation has thus been opened out, as it appears to be possible that the organisms of other chronic diseases, including that of syphilis, might possibly also be broken up in the system by similar methods.

Sodium morrhuate has now been under trial for a year, and from my own limited experience and the more extensive experience of Dr. E. Muir, M.D., F.R.C.S.E., of the Kulna Mission Hospital in the unhealthy Burdwan district of Bengal; of Captain R. Knowles, I.M.S., director of the Pasteur Institute, Shillong; of Dr. Caleb Davies, M.B., Ch.B., in Eastern Bengal, and of Lieut.-Colonel A. W. R. Cochrane, M.B., F.R.C.S., I.M.S., of the Bhowali Sanitarium, Kumaon Hills, to all of whom I am greatly indebted for trying the new treatment. I am satisfied that it is harmless. The three first named observers are convinced of its great value, although the last, with a shorter experience, is not satisfied that it has produced any permanent effects either for good or evil. Their reports will be published in full, together with my own more limited experience, in an early number of the *Indian Journal of Medical Research*, with details of the method of preparation, which is essentially the same as that of making sodium gynocardate already recorded.[3] Limits of space will only allow of a brief summary of the results so far obtained being recorded here to enable others to give the method a trial.

Dosage and Reactions.

In a case of old-standing lupus of the face, kindly sent to me by Miss Webb, of the Calcutta Dufferin Hospital, intravenous injections of sodium morrhuate produced a slight febrile and a definite local congestive reaction, similar to those obtained in leprosy. In phthisis similar febrile reactions occur, while occasionally there may be slight haemoptysis, indicating a local reaction in the affected lung tissue, which clearly point to a definite action on the tuberculous lesions. No harm has followed such reactions; frequently the temperature and other symptoms have improved decidedly after them. Their occurrence indicates the necessity for the precaution of increasing the doses very gradually. I usually begin with ½ c.cm. of the 3 per cent. solution, and increase by 2 to 4 minims at each injection, which may be given two or three times a week until any reaction occurs; then a week's interval is left and the dose reduced. The injections are given subcutaneously until they reach an inconvenient size, such as 2 c.cm., when intravenous injections can be begun with ½ c.cm., gradually increased in the same way as with the subcutaneous ones. Dr. Muir finds he gets the best results by pushing the dose until a febrile reaction occurs and then returning to a small dose and gradually increasing it again. In febrile cases the doses should be smaller and more slowly increased than in afebrile ones. He has gone up to 4 c.cm. intravenously two or three times a week.

Progress.

Improvement in phthisical cases is seen in reduction and cessation of the fever, diminution of the expectoration and cough, and steady gain in weight, the last being a very marked and satisfactory feature. In addition, the tubercle bacilli in the sputum greatly decrease in numbers, and may in time disappear. Moreover, they commonly show deficient acid staining and a granular or beaded appearance, indicating that they are actually being destroyed within the tissues. Captain Knowles has especially observed these changes, while Dr. Muir and I have also noticed them.

For example, the first phthisical patient I treated had extensive breaking down of the right apex, fever, profuse expectoration, and most distressing cough preventing sleep. When a 1 c.cm. dose was reached she had a reactionary rise of temperature, followed by a normal temperature for a week, and only a few rises to 100° F. later. The sputum and cough gradually subsided and she gained 10 lb. in weight in two months. Seven months later she wrote that she was keeping well in spite of having passed through an attack of influenza.

Another remarkable case was a missionary, sent to me by Dr. Caleb Davies, with slight affection of the right apex and early tuberculous epididymitis, both of which cleared up after twelve injections of sodium morrhuate. A patient with tuberculous disease of the knee put on 9½ lb. in four months and improved in his general health while having the injections, but of course he also had rest in bed with splints, and no conclusions can be drawn from a single case of joint tuberculosis.

Clinical Reports.

As my opportunities for clinical trials are necessarily very limited, the following abstracts from the reports which have reached me from reliable clinical workers are of more importance than my small experience.

Dr. Muir has had a year's experience of the new treatment and he reports that he is strongly convinced of the great usefulness of the drug. He has noted increased expectoration accompanying a febrile reaction and advises measuring the sputum in graduated bottles and taking the temperature frequently to detect slight reactions. In phthisis he considers the results to be far superior to those produced by tuberculin, and although he does not yet claim any cures, he thinks the results "are sufficiently encouraging to lead to the hope that the cases under treatment will be finally cured." His previous experience at Kulna makes him regard the climate there as exceedingly inimical to tubercle, so that spontaneous improvement can be eliminated, yet in all but the most

*Sodium morrhuate is being manufactured by Messrs. Smith Stanistreet and Co., Calcutta. Their London agents are Messrs. Evans, Son, Lescher, and Webb, Ltd., 60, Bartholomew Close, London, and of 92, William Street, New York.

advanced cases improvement was obtained under sodium morrhuate, and he thinks that even more favourable results might be obtained under better climatic conditions. In pulmonary phthisis he summarizes his results thus:

(*a*) Rapid diminution in the amount of the sputum in lung cases. (*b*) Rapid putting on of flesh and weight. (*c*) Diminution in the fever in febrile cases. (*d*) Increase in weight and strength. (*e*) Diminution in the number of the tubercle bacilli in the sputum.

In gland cases he noted reactions in the form of fever and local swelling, followed by very marked and rapid improvement, matted glands becoming discrete, and later all but disappearing.

Captain Knowles has also had nearly a year's experience of the treatment, and records valuable detailed accounts of his cases. He concludes as follows:

I am not yet satisfied that the drug is a specific cure for tuberculosis. I am, however, certain that it is at present the best line of treatment for tuberculosis in general. Tuberculin in unskilled hands is about as dangerous as prussic acid.

He regards

The marked increase in weight as the outstanding feature of the series; along with this, very often, goes a persistently normal temperature. The general health of the patient often shows a marked improvement. For early cases the treatment is an admirable one.

His first case was a serious one, with fever, cavitation, night sweats, repeated haemoptysis, paroxysmal cough, and sputum loaded with tubercle bacilli. This patient improved rapidly, and his sputum is now free from tubercle bacilli, while he has done full work for six months past. Captain Knowles also reports several earlier cases with very favourable results, and apparent cure in some. He has used comparatively small doses every fourth or fifth day, and has aimed at avoiding anything in the way of a severe reaction. In two of the cases clearing up of physical signs in the lung was demonstrated by means of *x*-ray observations before and after the course of injections.

Major C. Brierley, I.M.S., civil surgeon of Peshawar, has also kindly reported to me the two following remarkable cases. The first was a man with advanced phthisis, who was treated with 2 c.cm. doses of a 3 per cent. solution of sodium morrhuate intramuscularly three times a week for two weeks, and 2 c.cm. sodium gynocardate intravenously once a week for the next fortnight owing to sodium morrhuate running short, after which sodium morrhuate was again used. During the first week he was worse with high fever and increased expectoration—a severe reaction, after which he rapidly improved, and at the end of a month had gained 8 lb. in weight. At the end of six weeks no expectoration could be obtained, and he had gained 12 lb. during the last three weeks.

The second case was a boy of 15 with apical phthisis, very extensive breaking down of glands in the neck with numerous sinuses, which had resisted repeated operations, and a greatly disorganized and suppurating wrist-joint indicating amputation. He was also treated with 2 c.cm. doses intramuscularly, and at the time of writing, six weeks later, the lung signs had disappeared, many of the sinuses in the neck had healed without any surgical treatment after more rapid breaking down of the glands in some of them, and the condition of the wrist had decidedly improved.

Such cases as these afford great hope of the new treatment proving to have a permanent value in tuberculosis.

Conclusion.

I fully realize the great responsibility of bringing forward a new treatment for such a serious and widespread disease as tuberculosis. A year's trial by several careful workers has, however, convinced me that it is harmless in the doses recommended, which is more than can be said of that double-edged weapon tuberculin, regarding which, after over a quarter of a century's world-wide trials, scarcely two experts are agreed, either on the doses or the particular preparation to use, although no one doubts the great harm it often does in inexperienced hands. At the same time, the fact that sodium morrhuate causes febrile and local reactions necessitates great caution in pushing the drug beyond the limits which have so far proved safe, and a warning is required regarding the possibility of harm being done by its injudicious use. With this caution I feel that the results already obtained justify me in bringing sodium morrhuate to the notice of the medical profession, to allow of the prolonged trials by many skilled workers which will be necessary before its permanent value, if any, can be decided, and the indications and contraindications for its use worked out.

References.

[1] British Medical Journal, October 21st, 1916. [2] *Ind. Journ. Med. Research*, October, 1917. [3] Ghosh, *Ind. Journ. Med. Research*, April, 1917, p. 691.

THE TEACHING OF OBSTETRICS AND GYNAECOLOGY TO MEDICAL STUDENTS.

A General Survey of the Subjects to be Taught and of the Methods of Teaching Them.*

by

W. S. A. GRIFFITH, M.D.,

Physician Accoucheur to St. Bartholomew's Hospital, London.

The importance of a thorough training in obstetrics for students of medicine, who with few exceptions will enter general practice, is generally accepted. My duty this evening is to introduce a discussion on this subject in order that we who have the great responsibility of teaching may consider our aims and methods, so as to ensure that our training shall be as perfect as possible and our students made capable of rendering the great service to the nation that the efficient care of mother and infant can afford.

We who are teachers can help each other by comparing our methods; those who have profited more or less by our teaching can assist us even more by pointing out from their own experience of practice where our teaching methods have been deficient. We shall welcome candid criticism from any source, directed not to schools or individuals but to the methods which are more or less common to all.

Gynaecology is so intimately bound up with obstetrics that any attempt to teach these as separate subjects is futile, though there is much in each subject to be taught independently. It appears to me that our aims should be to give the student a good general knowledge of the special diseases of women in order that the practitioner may be able to deal adequately with the simpler cases, and to know when he ought to obtain more skilled assistance. Preventive gynaecology necessitates very thorough teaching—the prevention of infection, the prevention of the extension of infection, and the prevention and the early relief of various complications of pregnancy, labour, and the puerperium, such as lacerations and imperfect involution. While advanced and operative work is for the graduate who has the time and opportunity for further study, our aim should be to stimulate every student to take a keen interest and pride in the advancement made and to be made in our knowledge of these subjects, and so far as in him lies to do something towards the elucidation of the many problems which await solution.

I. Subjects to be Taught.

The obstetric anatomy of the pelvis must be taught by the obstetrician. The anatomy of the pelvic organs, not necessarily in minute detail, but the gross anatomy, must be taught with the greatest accuracy.

The Physiology of the Generative Organs.—Menstruation, puberty, and the climacteric: This subject, so fundamental to gynaecology, is generally neglected by the teachers of physiology, and must be taught by the obstetrician whose experience will enable him to give the student a view of its far-reaching importance in health and disease, mental and physical.

Pregnancy.—(1) The general structural changes in all parts of the body affected by pregnancy as well as the special organs and their functions, by which the symptoms and physical signs are recognizable in diagnosis. (2) The general development of the ovum into the mature fetus, placenta, and other parts. (Minute details of development are unnecessary in this course.) (3) Morning sickness. (4) Duration of pregnancy and the prediction of the probable day of confinement. (5) The various positions of the fetus and the means for recognizing them.

* An introduction to a discussion in the Section of Obstetrics and Gynaecology of the Royal Society of Medicine. Other parts of the discussion will be reported next week.

Labour.—(1) The general process and phenomena. (2) The doctor's and nurse's duties in preparation for and during labour. (3) Anaesthetics and substitutes. (4) Drugs—ergot and pituitrin.

The Puerperium.—The process in general and phenomena. Lactation, breast feeding, care of the breasts; doctors' and nurses' duties, doctors' and nurses' fees.

Pathology.—(1) The pathology of pregnancy, intrauterine and extrauterine, with the diagnosis and treatment. (2) The pathology of labour: The treatment of many obstetrical complications should be taught, not only by methods applicable when skilled assistance, trained nurses and the most approved instruments are available, but in the circumstances when the attendant has to rely on himself and simpler resources. (3) The pathology of the puerperium. (4) The pathology of the young infant. (5) Artificial feeding of the infant.

II. METHODS OF TEACHING.

The means at our disposal comprise demonstration lectures; laboratory, museum and *post-mortem* work; clinical work, and teaching in wards and out-patient departments.

It appears to be obvious that all the subjects which involve diagnosis and treatment should be taught during the time that the student is engaged in his clinical work in obstetrics and gynaecology, and that instruction in obstetric anatomy, menstruation, normal pregnancy, and labour should immediately precede this course. Also, that as the practice of obstetrics and gynaecology is the practice of medicine and surgery applied to special organs and conditions, the student should have completed his course in those subjects, including pathology with bacteriology, before taking the special course.

I think we may take for granted that the long wearisome courses of lectures which were customary in the medical schools are not the best method of teaching any branch of medicine and surgery to students. I am equally sure that good lectures, well illustrated by personal experience, are of great value to advanced students who have already been grounded in the principles of the subject and have begun to obtain some experience of their own.

I am sure also of the value of demonstration lectures, well illustrated and with plenty of *viva voce* questioning, which helps to maintain the close attention of the students, and enables the lecturer to discover if they have learnt anything from his previous lectures. It is well to select men from the back rows for *viva voce*, men whose modesty or fear of the process lead them to take a back seat. One great advantage of lectures over the admirable textbooks of the present time is the opportunities which the lecturer has for emphasizing and repeating points of fundamental importance and for illustrating them from his own experiences. The subjects which can be well taught in this way are the obstetric anatomy of the pelvis and its contents, menstruation, the anatomy of pregnancy, of labour, of the puerperium, and the mechanism of labour, which should be taught with a fetus, not with the fetal skull only. I do not know of any doll which is sufficiently flexible. The whole of the remaining subjects, namely, the great bulk of them, should be taught by demonstration lectures accompanying clinical work in the wards and out-patient rooms.

With regard to gynaecology, the large out-patient departments of the hospitals, if properly organized for teaching, afford most valuable means of instruction, the students attending for three months and having charge of the cases allotted to them, preparing the notes and examining the patients individually with the physician. The chief difficulty I had personally during the thirty years that I assisted or was in charge of the out-patient department of St. Bartholomew's, was from the large number of patients who attended, and it was necessary for one of my clinical assistants to supervise the case-taking by the students and to prepare a list of cases so that I could select those I required for teaching. If the case-taking is done systematically, according to a scheme of which each student has a copy, and accurately (a very difficult thing for the beginner, the patient misunderstanding the question and the student her answer), he will gradually acquire the power of forming correct opinions about the nature of the ailment from the history alone—a very valuable asset to the young practitioner, especially in gynaecological cases where the patient might hesitate to allow him to make a proper examination.

This personal responsibility for forming correct opinions for diagnosis, prognosis and treatment cannot be inculcated too soon; it is an unpleasant experience to have to begin to acquire it in practice. The amount of time that this kind of instruction takes is considerable, and much patience is needed, but the value not only to the individual student but to the whole class is well worth it, and it gives rise to much good humoured criticism, not only on the part of the other members of the class, but often by the patient herself.

Out-patient Obstetric Work.

This comprises two distinct departments: (1) The attendance by students on patients in their own homes; (2) the attendance of pregnant women in the out-patient department of the hospital.

The value of the former to the student, if he has had the necessary instruction as well as experience in the proper management of cases in the labour and lying-in wards, is very great. The responsibility he meets with compels him to find out his deficiencies on the one hand, and gives him confidence and self-reliance on the other. The results obtained bear witness to the care taken by students of their patients, and to the great freedom from the calamities of obstetric practice. This attendance of patients in their own homes is also of great value in bringing the student into direct touch with the domestic difficulties and social relations of the poor, and in developing that sympathetic feeling for their troubles and privations so characteristic of our profession, and which is so often accompanied by their practical advice and unostentatious assistance.

The value of the training to the student attending this department is also great if he is held to be personally responsible for the history and examination of the patients. He learns to diagnose pregnancy when advanced, not usually a very difficult procedure, but one in which most unexpected mistakes are not very uncommon even in the practice of men of experience. He learns to diagnose the position of the fetus and the presentation by abdominal and vaginal examination. He learns to measure the pelvis; if he also does this in the *post-mortem* room, where he can compare his results with the actual internal measurements, he will be in a better position to realize the uncertainties and errors of the method and its great value in certain circumstances. He will occasionally meet with breech and other abnormal presentations, and will learn the easy and advantageous operation of external version. He will occasionally meet with other complications and learn how to recognize and deal with them. He will examine the breasts, and learn what can be done to relieve conditions which may interfere with lactation. He will examine the urine, and in doubtful cases obtain a catheter specimen. He will examine the vulvo-vagina for evidence of infection, and learn to take the necessary steps for thorough disinfection and treatment. He may meet with cases of chorea or early mental trouble, but for the treatment of mental cases he must visit an asylum and learn the principles of treatment which, if properly carried out, are followed by such a high proportion of recoveries. Above all, he will learn the value of the systematic examination of all women advanced in pregnancy, and the advantage of being sure that all important details are normal before confinement, and be forewarned of difficulties and complications.

Gynaecology.

The chief difficulty in ward teaching at the present time is due to the abundance of surgical material which interests and occupies the time of the gynaecologist to the exclusion of cases of great importance for teaching. Some experience of the major operations, though advantageous, is of small value to him, and he learns too little of the minor gynaecology which will come to him in general practice, and he is induced to take little interest in cases not needing operative treatment. What, for instance, does the student learn about the treatment of the ordinary common cases of dysmenorrhoea, of the methods for the relief of cases of inoperable carcinoma which he will have to attend to the end?

When we consider the clinical means for teaching obstetrics, that most important branch of practice for every general practitioner whose ignorance or want of care

may lead to great suffering and long illness, and may even involve the life of his patients and their babies, and, indeed, that of his own wife and child, we find ourselves face to face with great difficulties. Owing to the better systematizing of our small resources we are somewhat better off than in 1906, when I had the opportunity in Toronto of discussing this subject in my address at the meeting of the British Medical Association. How can any branch of medicine and surgery be properly taught in an out-patient department only—and the department scattered over an area of, say, a square mile, with no real and effective supervision, and without the aid of competent nursing? Hospital authorities have provided a few beds for special cases, but though these are of immense value what are they but a pittance?

I am not of the opinion that the value of a hospital for teaching purposes is necessarily improved in proportion to the large number of its beds; this depends on the number being adequate and on the ability of those in charge of it to make the best use of them. At Queen Charlotte's, where I worked regularly for twenty years, we had admirable opportunities for teaching. We had the great advantage of teaching at the bedside and in the labour wards mixed classes of students and post-graduates, together with midwives and monthly nurses, and it would be difficult to determine who gained most from the mixed classes—the students, who soon discovered how little they knew of the nurses' duties, or the nurses, who gradually began to realize their own ignorance and the difference between their superficial training and that of the doctors. This combined training, if general, would, in my opinion, also do much to place the relations of doctor and midwife on the friendly footing of mutual confidence and help that should exist for the benefit of the poorer women and their infants.

It is in the organization of maternity wards or hospitals in our great teaching centres, comparable to those devoted to medicine and surgery, that we must look for our next great improvement in the teaching of obstetrics, and without these we are severely handicapped in our endeavours. A three months' combined course in obstetrics and gynaecology, the whole time being given up to the subjects, would probably prove to be sufficient.

A CRITICISM OF SOME MODERN METHODS OF INFANT FEEDING.

BY

G. D. LAING, M.D.,

LIMPSFIELD, SURREY.

I VENTURE to submit these few notes, on a subject of some importance, as the result of long and close observation of the progress of babies in general practice.

The following is approximately the method of artificial feeding adopted by some of the large London hospitals and institutions:

The baby is not fed for the first forty-eight hours after birth; he may be given a little sterile water. After this period the following mixture is used for the first week: milk (sterile) 1 part, water 3 parts, with sugar about 10 grains and cream 5 minims to an ounce of the mixture. This is given every four hours on the third day, and on the fourth day every three hours from 7 a.m. to 10 p.m. From 10 p.m. to 7 a.m. only one feed is given, making in the twenty-four hours a total of seven feeds. The quantity allowed at each feed is 1½ ounces for the first week, sometimes 2 ounces. During the second week the mixture is strengthened to half milk and half water, and the quantity is increased to 2 ounces; the intervals are kept the same.

This method is apparently adopted in all cases irrespective of the size of the infant or his evident appetite. The principle of such feeding seems to me to be wrong, for I cannot see that it is a good imitation of the way in which a baby or any other young animal is naturally fed. The mixture is probably more or less correct, for it resembles the composition of the mother's milk; but, in my opinion, the quantity and the intervals between feeds are in many instances unsuitable, for the following reasons:

(*a*) *Quantity.*—A young healthy infant always sucks at the breast until he is satisfied; in doing this he very often empties it. The amount of milk which can be drawn from a woman's breast is usually about 2½ or 3 ounces, though it may of course be less. It seems to me unreasonable to give an infant less food than it would get from a healthy mother.

(*b*) *Intervals.*—In the course of a good many years of general practice I have asked nursing mothers how long intervals they gave between feeds. The answer is nearly always two to two and a quarter hours, perhaps two and a half hours, never longer, for at least the first month, except at night. When asked why they do not give longer intervals, some or all of the following reasons are invariably given: (1) If the interval is lengthened the baby cries a great deal; (2) the nights are bad because the baby does not sleep for many hours at a stretch; (3) the breasts get swollen and painful. These are very sound reasons for not giving long intervals.

From observation of many cases I am sure that bottle-fed babies do better, increase in weight and sleep well if the intervals are short. I have often been asked why the baby cries so much, and in nine cases out of ten I have told the mother to give the food more frequently and the baby ceases crying (provided it is allowed enough). Perhaps it is not realized how harmful it is to a mother to have her baby crying a great deal; she gets bad nights, feels worried, and becomes restless and nervous, and her recovery is very much retarded.

About twenty or twenty-five years ago a great deal was written and said about infant feeding, and it was pointed out that babies were grossly overfed; this was quite true in many instances, for they were given milk and very thick barley-water and much sugar and cream, and the food was more or less forced down their throats; but now we have gone to the other extreme and in consequence a great many infants are underfed and some nearly starved.

No hard and fast rule can be laid down as to the quantity of food an infant should be allowed irrespective of his size, weight, and natural appetite. It is obvious that a 10 lb. baby requires more food than one of 6½ lb. I believe also that some babies digest their food more completely than others, exactly as in the case of adults, so that even with babies of the same weight one cannot be sure that they will do well on the same quantity of food.

The method I advocate is as follows:

(*a*) *Breast-fed Babies.*—The baby is put to the breast from twelve to sixteen hours after birth, and about every six hours after this until the milk comes. If he cries and seems thirsty he is given sterile water. After the milk has come the baby is put to the breast at least every two hours from about 8 a.m. until 10 p.m., leaving him there till he is satisfied, and, if necessary, waking him at the right times. A good supply of nourishment is thus obtained during the day so that much food is not needed during the night. After 10 p.m. the baby is allowed to sleep as long as he will; he usually has to be fed once or perhaps twice between 10 p.m. and 8 a.m.; after the first two or three weeks a baby will often sleep six or even eight hours at a stretch if he has had enough food during the daytime. In some cases, where the baby is small and weak and can only take a little food at a time, and wakes and cries within two hours, he is fed every hour and a half for the first seven days, or even longer. As the infant grows older the intervals of feeding can be gradually lengthened as a rule; about the third or fourth month, or sooner, the baby is often on three-hourly feeds, but this depends on the comfort of the mother and the appetite of the baby, and must not be a hard and fast rule.

(*b*) *Bottle Feeding.*—I endeavour to imitate nature as closely as possible; the times of feeding are practically the same as in breast-fed infants. The mixture is as follows, subject to variations: For the first two or three days 1 part milk, 3 parts water, cream ½ drachm, sugar ½ drachm to each feed. After this the mixture is gradually strengthened, till at the end of fourteen days it is 1 part milk, 1½ parts water, 1 drachm cream, rather less than a drachm of sugar to each bottle; sodium citrate or sodium bicarbonate may be added. I do not want to emphasize the ingredients or strength of the mixture, or the variations which may be necessary, but to insist that enough must be given to satisfy the infant. The easiest way to make sure of this is to put enough of the mixture in the bottle, let the baby have it from twenty to thirty minutes (the hole of the teat being of a suitable size), and then take it away. If a baby finishes every bottle it is fairly certain that he is not having enough. A baby, like an adult, takes more at one meal than another, and it therefore follows that there should be something left in some of the bottles. I have found that the actual quantity varies very much, as one would expect—a 10 lb. baby takes more food than a 6½ lb. baby, as a rule, though not always. Some babies are quite content on the stereotyped allowance of 1½ oz. for the first week and 2 oz. for the second; others need much more. In the second week it is common for a baby to require quite 3 oz. in some of its feeds, notably in those following a long sleep. If a baby gets nine feeds in the twenty-four hours with an average of 2½ oz. a feed he will get 22½ oz. in all. This is not an uncommon amount for an 8 lb. or 9 lb. baby to take, but some will require even more; others rather less.

Many doctors would object that by this method the baby would be grossly overfed, but I contend that it is difficult

to overfeed a baby, provided the strength of the mixture is right, the hole in the teat is not too large, and the baby is not allowed to suck too long. A baby at the breast takes as much as he wants, and only leaves off when he is satisfied; a baby at the bottle should do the same. If a breast-fed baby gets a little too much he regurgitates the surplus quite easily; a baby at the bottle does just the same. I would even go so far as to suggest that if a baby does not occasionally bring up a little food he is not getting enough to eat.

Unfortunately there is a school that teaches that the correct way to feed an infant is to give it a limited amount of food at three or even four hourly intervals. Most text-books recommend intervals of about two hours, but nearly all lay down the exact amount of food to be given at each feed, even to within ¼ or ⅛ oz., which to my mind is absurd. In two works a rational method is advocated: Hutchison and Stanfield Collier's *Index of Treatment* recommends that the baby be allowed to suck until he is satisfied, as he will easily regurgitate any surplus, but the amount of food is not mentioned. Tweedy and Wrench give the quantity of from 1 to 3 oz. at two-hourly intervals; this variation seems to me sound.

It is true that the infant mortality has much decreased of late years, but this, I suggest, is not due to the system of starvation, but to the general introduction of regular feeding, cleanliness, and the better mixture of the food. The system of long intervals and limited feeds is being advocated at many infant welfare centres, and I fear it will bring discredit on them, for the mothers will find that babies fed in this manner do not do so well as others, and that the plan often has to be abandoned.

A fitting judgement on those who condemn infants to be fed at such long intervals on such small quantities would be for them to live the rest of their lives in a small house with a succession of such babies and listen to their pitiful cries by day and by night.

TREATMENT OF EARLY SYPHILIS.

BY

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IT is necessary in treating early syphilis to have a definite system of work, and to keep records for a stated term before making any deductions.

Mercury alone can cure many cases of syphilis if persisted in for a sufficiently long time, but it is questionable if a course of less than two years is of any value at any stage of the disease.

With salvarsan and its alternatives, however, the term of active treatment can be greatly shortened, and in the very early stages of the infection the disease can be aborted, although it may be advisable to keep the patient under observation for two years.

The following observations are made from the standpoint that a positive reaction is indicative of syphilis in its secondary stage, and that the disappearance of the positive reaction for six months after treatment with mercury has been discontinued is evidence of cure. These views are easily open to controversy, but I have not seen a case of secondary syphilis—which has not had any treatment—give a negative reaction; nor have I seen a case of secondary syphilis which gave a negative reaction for six months after treatment with mercury and salvarsan was discontinued again develop a positive blood test, unless reinfected.

In the scheme I suggest the terms "primary" and "secondary" are interpreted not according to clinical signs but according to the blood test.

Primary or Pre-positive Stage.

This stage extends from the date of infection until the blood test becomes positive. The length of this stage is variable, depending on many factors, such as the virulence of the infection, the resistance of the individual, and the delicacy of the test. I would put it at less than six weeks. In secondary syphilis the blood test has become positive though the clinical signs may not have appeared.

Course of Treatment of Primary Syphilis.

(Neokharsivan, novarsenobillon, or galyl given by intravenous injection; mercury by intramuscular.)

Day.	N., or NAB.	or Galyl.	Mercury.
First (consultation) ...	—	—	gr. ¼
Second	0.45 gram	0.25 gram	—
Ninth	0.45 ,,	0.25 ,,	gr. j
Sixteenth	0.6 ,,	0.30 ,,	gr. j
Twenty-third	0.6 ,,	0.30 ,,	gr. ¼
Thirtieth	0.75 ,,	0.35 ,,	gr. j
Thirty-seventh	0.75 ,,	0.35 ,,	gr. j
Forty-fourth	0.9 ,,	0.40 ,,	gr. j
Fifty-first	0.9 ,,	0.40 ,,	gr. j

N.=Neokharsivan. NAB.=Novarsenobillon.

This constitutes a course, but if the patient can stand two further weekly injections of mercury I prefer to give them. Local inunction of calomel ointment is ordered for the chancre.

At the end of five weeks potassium iodide gr. x is given three times a day for a week, and a blood test performed. If this is negative another test is performed twelve weeks later, and if this is negative the case is looked on as cured.

In many very early cases this course may be too long, but for the bulk of cases it is good, and from it satisfactory results may confidently be anticipated.

Secondary Syphilis.

In this stage it must be presumed that a profound change has taken place in the patient, and consequently the prognosis is not so good, and the treatment must be correspondingly lengthened. The course advocated for primary cases is given, and at the end of six weeks, if the blood test is negative, a second course of six weekly injections of mercury gr. j is given. This is followed by three similar courses at intervals of eight, ten, and twelve weeks. If the reaction is negative twelve weeks after the fifth course, a wait of another twelve weeks is enjoined before another test is performed. If this is negative the patient is looked on as cured. The idea by which the scheme is inspired is to nurse the case towards a six-month negative blood test.

The total length of time that a favourable case of secondary syphilis is under observation is seventy-four weeks, during which there are thirty weeks of active treatment.

The object of giving potassium iodide at the end of a definite time after the mercury is that I think it gives a better chance of getting a positive blood reaction. This may or may not be so, but I do not believe that iodide can render the reaction negative, as I have seen cases of obstinate tertiary palmar and plantar lesions in which iodide has been given for very long terms still show a strongly positive reaction.

The iodide is not given immediately the mercurial course is finished, as I have seen cases which stood the mercurial injections well develop mercurial poisoning when the iodide was given too early. The drugs used for intravenous injection have been galyl, neokharsivan and novarsenobillon. So far as I am able to judge, the results have been pretty much the same with all these preparations. Novarsenobillon is the most readily soluble and can easily be given with a syringe. Should any of the solution get into the subcutaneous tissues the pain—which is slightly delayed—is very acute. What I mean by "slightly delayed" is that the swelling caused by the effusion of the solution is noticed for some minutes before the patient complains. The subsequent reaction of the tissues is very great. The local effects of slight effusion of galyl and neokharsivan are not so great. Galyl, in the earlier days, was not readily soluble and did not appear to be always uniform in composition, that is, judging by the look of the solution, but this seems to have been remedied in the later preparations. Mercury emulsions of 10 per cent., 20 per cent., and 40 per cent. have been used.

I find that private patients bear intramuscular injections of mercury better than hospital cases, and in the latter class miners and footballers often complain so bitterly that

oral administration has to be substituted for the intramuscular method. Should a positive test be obtained after the first course, then three intravenous injections of the salvarsan alternative are given with the second course, which is called an intermediate course, but this does not interfere with the second, third, fourth, and fifth courses. This means a lengthening of the whole course of treatment by six weeks and of observation by twelve weeks.

Causes of Bad Results.

1. *Age.*—Patients contracting syphilis after the age of 40 seem to have more difficulty in becoming cured, as judged by the blood test, than younger cases.

2. The longer the delay in starting treatment after infection the more disappointing are the results, and vice versa.

3. *A Virulent Infection.*—This may be explained either by a low resistance of the individual or a high virulence of the syphilitic virus, or a combination of both. Clinically, it appears impossible to state when one is dealing with such a case. I would, however, state that it is difficult to get and keep the reaction negative in rupial syphilis.

4. Alcoholics are a class in which it is difficult to get good results, and for this reason total abstinence is always enjoined.

5. If the teeth are bad and the mouth septic, as so often happens in hospital cases, oral administration is to be preferred to the intramuscular method, because, if the gums are "touched"—a point of saturation with mercury to be aimed at—an uncontrollable stomatitis is liable to be set up.

6. There are a limited number of persons who do not stand mercury well, and in these the prognosis is not good. There are also a limited number who show idiosyncrasy to intravenous medication with arsenical compounds. I would give a more guarded prognosis in the case of secondary syphilis with idiosyncrasy to mercury than in the case of idiosyncrasy to arsenic compounds.

Suppose a man presents himself with an early chancre on the penis and states that he has exposed his wife recently to infection, it seems debatable whether the woman ought not to be given a few intravenous injections of salvarsan substitutes. I quite admit that it could never be known whether she had been saved from general infection or not, but when we consider the enormous difference between early and late treatment it seems a suggestion worthy of further thought.

THE TREATMENT OF VENEREAL DISEASE.

BY

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AND

SURGEON COMMANDER P. HAMILTON BOYDEN, M.D., R.N.

EVERY great war has been followed by an increase in venereal disease, so marked that on occasions it has amounted to a pestilence. Unless timely sanitary precautions are taken the greatest of all wars is unlikely to furnish an exception to the rule. We think it desirable, therefore, to give an account of an essay in preventive medicine, which, as may be judged from the following, achieved considerable success.

One of us (A. R.) has been in medical charge of a rapidly changing body of men generally numbering about 2,000. Up to the end of 1916 venereal disease was common among them in spite of numerous moral lectures and in spite of adequate provision of what is known as "early treatment"—that is, disinfection after the "contact" has returned to quarters. At the beginning of 1917 a new system was instituted. The men were instructed to disinfect themselves immediately after danger had been incurred—just as a surgeon would disinfect his hands. This procedure is what is known as prophylaxis. It differs from early treatment merely in that the man carries the disinfectant and uses it immediately. Each man who applied was given an ounce of solution of potassium permanganate (at first in a strength of 1 in 2,000, later in a strength of 1 in 1,000), a small swab of cotton-wool, and careful directions. Potassium permanganate was chosen merely because it happened to be the most accessible disinfectant. The rationale of the procedure was fully explained, so that on an emergency the man could purchase the materials from any chemist. During 1917 and 1918 about 20,000 men passed through the station, and among them precisely seven cases of venereal disease occurred, six of gonorrhoea and one of syphilis. Of the six cases of gonorrhoea, two only were contracted by men on leave, in each case from the man's own wife. Two of the others were drunk and took no precautions. The fifth man was infected the night he arrived, and he also, being unaware of the system, took no precautions. The sixth man practised early treatment an hour after intercourse. The man who acquired syphilis also carried no disinfectant, and used it (permanganate and calomel) two hours after intercourse. He had a long prepuce, and therefore a sensitive glans, and probably did not—probably could not—rub in the calomel vigorously.

The other of us (P. H. B.) commenced prophylaxis against venereal disease in the Royal Navy in 1907. Some eighteen months ago he took over medical charge of an establishment numbering over 2,000 officers and men. The amount of venereal disease, and especially gonorrhoea, was considerable, and it was recognized that of the men who stated they had used the so-called "dreadnoughts" some 40 per cent. contracted the disease. It thus became evident that nargol jelly as a preventive was practically inert. For the past nine months the method of immediate prophylaxis by means of the application of a solution of potassium permanganate (1 in 1,000) has been employed, with results as striking as those mentioned above in the case of the soldiers. Not a single case of gonorrhoea occurred amongst those employing this method, and only one of syphilis. This latter made the application about six hours after exposure to infection, and may therefore be counted out. Unfortunately the navy is a very conservative body, and many men still persist in sticking to the "dreadnoughts." But in lectures given on the subject of prophylaxis men are gradually being convinced of the simplicity and efficacy of immediate prophylaxis. The calomel cream is still reserved for those who have omitted to carry the permanganate solution on their persons, as it seems likely that the former affords some protection, even if an hour or two has elapsed since the risk of infection has been run.

It will be seen that no man, who followed instructions and disinfected himself immediately, acquired disease. Evidently the time element is of extreme importance. Probably there is no special virtue in potassium permanganate. Any other active antiseptic would be equally effective. But permanganate is the cheapest disinfectant and the best known to the public, the least poisonous, and least irritating.

PROFLAVINE OLEATE IN THE TREATMENT OF OPEN WOUNDS.

BY

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AND

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WE desire to draw attention to the value of proflavine oleate in the treatment of certain war wounds, notably those in which an exceedingly tender raw surface of considerable extent exists, the dressing of which is productive of acute pain. Such wounds are typically seen in amputation stumps, either without flaps or with flaps left unsutured, and before the process of granulation has set in. In many of these cases superficial sloughing is going on, and the immediate edges of the adjacent skin are reddish, swollen, and indurated. These wounds are exquisitely sensitive, and the removal from them of an adherent dressing is an agonizing process to the patient. In many instances these men are very ill, and their fortitude has been broken by the combined effects of shock, haemorrhage, toxic absorption, and the suffering occasioned thereby.

The dressing with which such patients usually arrive is of gauze soaked in some antiseptic in watery solution. The water soon evaporates and the gauze adheres tightly to the raw surface. This disadvantage is obviated by the use of proflavine oleate.*

*The preparation consists of 1 per cent. proflavine oleate contained in an ointment of suitable consistence, which is made up of paraffin and calcium carbonate in about equal parts by weight. For the production of proflavine oleate in quantity sufficient for clinical use we are indebted to Messrs. Boots, Nottingham.

The method we have adopted consists in either spreading a thick layer of the oleate ointment on a single thickness of white gauze and then applying it to the wound, or spreading the oleate direct on to the surface of the wound and then covering it with a single layer of gauze. This dressing does not need to be changed for several days, and, when it is removed, strips off from the sensitive surface without any dragging or pain. It is equally applicable to any large flat-surfaced wounds, such as those left after wholesale excision of the thigh or buttock muscles, and so forth.

We have used this dressing continuously until granulation was complete; the process appeared to occur normally, no retardation or deficiency of formation of granulation tissue being observed. It has the advantage that it adheres sufficiently of itself and requires no bandage or pad to retain it in contact with the wound. The injured part can therefore, except for its covering of proflavine oleate gauze, be left fully exposed to the air under a bed cradle covered with a layer of butter muslin.

We would suggest that after all operations in which a flat raw surface is necessarily left, the wound should, from the first, be dressed with proflavine oleate, in the manner we describe.

NOTE ON THE CHEMICAL AND ANTISEPTIC PROPERTIES OF PROFLAVINE OLEATE.

By C. H. BROWNING, M.D., D.P.H.,

Director of the Bland-Sutton Institute of Pathology, Middlesex Hospital.

Proflavine oleate is the oleic acid salt of 3.6 diaminoacridine (the sulphate of this base being the water-soluble proflavine which has already been employed as an antiseptic in wounds). This compound is one of various salts prepared by Dr. E. L. Kennaway of this department with a view to obtaining flavine derivatives whose chemical and physical properties should fit them for special uses. Proflavine oleate is comparatively insoluble in water; but when this substance or the ointment containing it is shaken with serum the latter dissolves sufficient of the compound to acquire marked antiseptic properties. Thus the use of proflavine in the form of oleate enables a "dépôt" of antiseptic to be placed at the disposal of the tissues.

SOME EXPERIENCES OF THE RECENT INFLUENZA EPIDEMIC IN BRISTOL.

BY

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OVER 400 cases of influenza came under my care during the recent epidemic in Bristol.

Civil Cases.

I first noticed what appeared to be cases of influenza in civil practice at the end of May, 1918. The patients, who complained of pain in the limbs, feverishness, and slight catarrh, recovered in a few days. In June the same symptoms were noted, with more fever. From July onwards the cases presented more marked pyrexia, and it appeared that three distinct types could be distinguished:

1. Very sudden onset; rapid occurrence of what may be described as acute bronchiolitis; oedema of the lungs, followed by death in two or three days.
2. Influenza, uncomplicated; slow recovery, followed by debility.
3. Influenza, with pneumonia, mostly broncho-pneumonia, which ensued after four or five days, followed in some cases by death, but usually by recovery with protracted convalescence.

There were three cases of the first type, two in July, one in October; all died.

There were over 60 cases in civil practice in July; they included six of pneumonia with two deaths; the deaths were of Type 1. From July 31st, 1918, to January 17th, 1919, over 200 cases were treated in my civil practice; of these, 38 developed pneumonia; there were eight deaths, two of which occurred in hospital. The total number of cases was greater than 200, but the number of deaths is correct.

The patients were largely of the artisan class, living in small rooms in a somewhat crowded district. For the most part isolation at home was impossible; there were many instances of a whole family being struck down, the incubation period ranging from a few hours to two or three days—in most cases a few hours. Many apparently weak individuals recovered and the more robust succumbed.

Several phthisical patients recovered, and similar fortune attended some cardiac cases. Two cases of acute cardiac dilatation occurred after the patients had resumed their occupations; both were examples of organic disease previously existing; both recovered ultimately.

Epistaxis was a not infrequent symptom; three cases required plugging. The help afforded by the health nurses, and the possibility of removal of bad cases to the city hospitals, were of great value.

Up to the end of July salicylate was generally given. Strychnine was useful in pneumonia; quinine was not used; alcohol was of value in suitable cases, but entirely withheld in convalescence. Oxygen was useful. No vaccines were used.

Summary of Civil Cases.—The total number of civil cases was over 270; pneumonia occurred in 44, 15 were removed to municipal hospitals and 3 to other hospitals. The deaths numbered 10.

Military Cases.

During this time I was engaged as Civilian Medical Practitioner at the White City Barracks, Bristol. There were 130 cases of influenza amongst the troops there. They presented somewhat similar features to those in my civil practice; cases I have designated as Type 1 were absent, and there were no deaths. In the early stages of the epidemic the cases presented, on the whole, a fairly high pyrexia, but recoveries were rapid and without any marked after-effects. Salicylate proved most effective in these early cases. Until June the camp hospital consisted of a wooden hutment, well ventilated, but inadequate for acute conditions or illness of any duration; it only served for very temporary accommodation. In June the new hospital was ready. Its construction and equipment, liberally supplied by the authorities, were quite sufficient for these cases, and so relieved other and more important centres much occupied at that time with the exigencies of the military situation.

On admittance patients were placed in the ward reserved for acute cases, and were not removed into the general ward until the temperature had remained normal for at least forty-eight hours, other things being equal. The infection did not spread to the general ward.

The worst cases occurred in October and November. There were twelve of pneumonia (bronchopneumonic type, scattered over both lungs) and one had a large amount of pleuritic effusion. All cases recovered.

One man showed signs of severe streptococcal infection with great prostration; this man had V.D.H. of some years' standing, after rheumatic fever. He had prolonged haemoptysis, and for some days his condition was hopeless; the urine was almost solid with albumin on boiling.

His illness began on October 30th, 1918, with a temperature of 100°, a much less severe onset than many lighter cases. After being up a fortnight he developed acute cardiac dilatation with rapid pulse and extension of cardiac dullness on December 7th. Suitable treatment proved availing, the albumin disappeared, and he is now walking about. No growth was obtained from a blood culture, which, unfortunately, was taken rather late in his illness; the Widal reaction was negative; he was inoculated in November, 1917.

Six officers, removed elsewhere, are not included in the record. They all recovered. One had a streptococcal infection of the throat, with much oedema; one was a relapse after a first attack three weeks previously.

From the onset of the epidemic all men on sick parade were treated with nasal and throat spraying with potassium permanganate and saline, and all troops warned to report if feeling the slightest symptoms of illness. Later, when the epidemic assumed a more serious aspect, thymol solution was used in Rogers's coarse crystal spray. All who slept out were so treated; the hospital and billets were daily sprayed with cresyl. Of nine women employed in the offices three acquired influenza and recovered. One female attendant in the officers' mess suffered, and out of ten in the canteen three had influenza mildly, and all recovered.

No vaccines were used either for prophylaxis or treatment. Four of the hospital orderlies were affected; one

had a slight attack in June, and one, whose duties were chiefly of an administrative character, in November; the two orderlies in charge of the scabies block had influenza mildly. Most of the men in the camp in June and July were also stationed there during the more severe times in October and November, but there were only two relapses, both severe.

Summary of Military Cases.—In May, 7; average strength of troops 1,300. In June, 5; strength 700. In July, 86; pneumonia 1; strength 490. In August, 3; strength 500. In September, none. In October, 11; pneumonia 4; strength 650. In November, 13; pneumonia 7; relapses 2; effusions 2; strength 600. In December, 5; streptococcal throats 2; strength 1,008. Total military cases treated 130. Pneumonia 12; relapses 2; streptococcal throats 2; deaths 0.

I am indebted to Major E. U. Bartholomew, R.A.M.C., S.M.O. I.W. and D.R.E., under whose administration the work was carried out, for permission to publish these notes. The nursing orderlies exhibited remarkable endurance, and to their many acts of unselfish devotion the record of no deaths is largely due.

The good results in the military cases were due, I believe, to the better surroundings, the preventive spraying, and the possibilities of close observation permitting of very early isolation.

OBSERVATIONS ON THE INFLUENZA EPIDEMIC IN THE BRISTOL GENERAL HOSPITAL.

WITH SPECIAL REFERENCE TO THE USE OF "N. PANE'S SIERO ANTI-PNEUMONICO" FOR PROPHYLAXIS AND TREATMENT OF PULMONARY COMPLICATIONS.

BY

A. J. LIM, M.D.EDIN., D.T.M.LIVERPOOL,

HOUSE-PHYSICIAN.

SINCE October 11th, 1918, seventy-six cases have been admitted under Dr. G. Parker and Dr. J. O. Symes, seven of which we have lost. Thirty-seven of the cases had double pneumonia and the rest had influenza.

INCUBATION PERIOD.

From the appended table and from the June epidemic the approximate average incubation period is seen to be about forty-eight hours.

Patient.	Probable Date of Infection. Date when Influenzal Case was Admitted into the Ward.	Onset of Illness.	Approximate Incubation Period.
Nurse A ...	Oct. 11, evening	Oct. 14, morning	60 hours
Nurse B ...	Oct. 15, evening	Oct. 17, evening	48 ,,
Nurse C ...	Oct. 20, morning	Oct. 22, morning	48 ,,
Nurse D ...	Oct. 25, morning	Oct. 27, morning	48 ,,
Nurse E ...	,, ,,	,, ,,	48 ,,
Nurse F ...	,, ,,	,, ,,	48 ,,
Nurse G ...	,, ,,	,, ,,	48 ,,
Nurse H ...	Oct. 25, 1 p.m.	Oct. 27, afternoon	50 ,,
Patient A ...	Oct. 18, afternoon	Oct. 19, 11 p.m.	30-33 hours
Patient B ...	Oct. 20	Oct. 22	48-55 ,,
Patient C ...	Oct. 22, morning	Oct. 23, evening	32-35 ,,
Patient D ...	Oct 29, afternoon	Oct. 31, morning	42-46 ,,
Patient E ...	Oct. 30, morning	Nov. 1, evening	50-56 ,,
Patient F ...	Nov. 2	Nov. 4	45-50 ,,

IMMUNITY.

One of the main characteristics of the present epidemic has been the escape from infection of the entire male staff, while the female staff suffered heavily. Of one hundred and four on the regular nursing staff thirty-six developed influenza, and about twenty maids out of a total of about forty were affected. This, no doubt, was due to the fact that in the June epidemic all the male staff and only six of the nursing staff were afflicted, and it is to be assumed that they must have acquired immunity from their previous attacks.

The question then arises, How have the remaining sixty-two nurses escaped infection? The prophylactic measures adopted consisted of gargling and the administration of a vaccine, consisting of ten millions each of pneumococci and streptococci, and fifteen millions each of *Micrococcus catarrhalis* and *Bacillus influenzae*. The injection was repeated a week later.

Of the vaccinated nurses, six developed reactions amounting to a mild form of influenza which lasted only for twenty-four hours.

SYMPTOMS, CLINICAL COURSE OF THE DISEASE, AND TREATMENT.

To facilitate the description of treatment the cases will be divided into three groups:

Group A. Simple influenza.
Group B. Simple influenza with commencing pulmonary complications.
Group C. Influenzal pneumonia.

Owing to the exigencies of space the symptoms and treatment of simple influenza will not be described here.

From the appearance of the respiratory system in three autopsies and from the symptoms often presented in influenzal cases, one would surmise that a descending acute dry inflammatory process occur in the respiratory system in cases which showed a tendency to pulmonary complication.

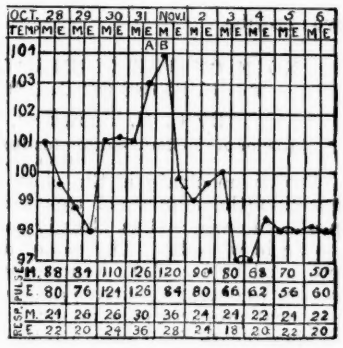


CHART 1.—This chart and Chart 2 illustrate the effect of antipneumococcic serum in cases under Group B. A, Serum 5 c.cm. B, Serum 10 c.cm.

In cases occurring under Group B it is to be gathered that the inflammation has spread to the smaller bronchi and the surrounding lung tissue, so that small and deep-seated bronchopneumonic patches develop either in one or both lungs, while later, such as in the cases under Group C, these deeply seated bronchopneumonic patches rise to the surface, becoming confluent with neighbouring patches, form quite a considerable patch of consolidation, but as both lungs are usually involved, patches of consolidation varying in size are usually present in both lungs. The importance of Group B is from the prophylactic point of view, but, unfortunately, the symptoms and physical signs are so vague that they are liable to be overlooked.

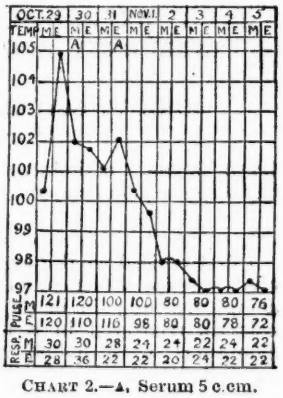


CHART 2.—A, Serum 5 c.cm.

The symptoms and signs which we depended upon as indications that this stage has been reached are as follows:

1. Persistency of the cough.
2. Gradual rise of temperature or a sudden rise of temperature after the previous temperature has reached normal, associated with a rise in the respiration rate usually to over 25.
3. One of the following signs in the chest: deficiency in the entrance of air over one portion of the lung; signs of generalized bronchitis, or the presence of dry or moist râles localized to some portions of the lung or lungs.

Charts 1 and 2 illustrate the beneficial effect of Pane's antipneumococci serum in cases under Group B. The serum apparently retarded the progress of the development of the respiratory complication, as indicated by the sudden drop of the temperature, also of the pulse and respiration rate, and the disappearance of the signs found

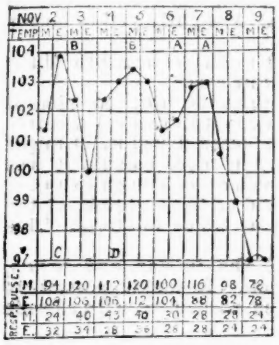


CHART 3.—A, Serum 5 c.cm. B, Serum 10 c.cm. C, Ninth day of illness; consolidation of right base. D, Consolidation of left base.

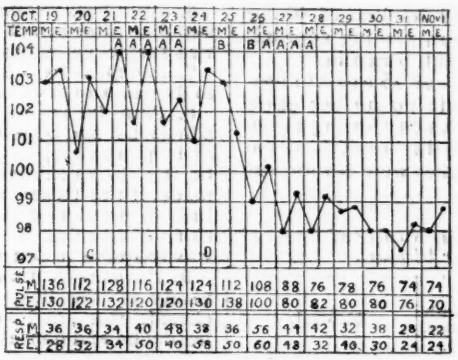


CHART 4.—A, Serum 5 c.cm. B, Serum 10 c.cm. C, Generalized bronchitis and consolidation of left base. D, Consolidation of right base.

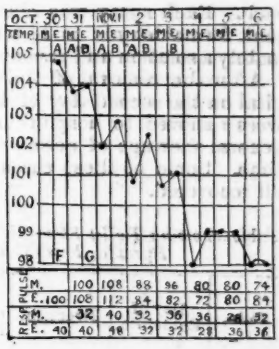


CHART 5.—A, Serum 5 c.cm. B, Serum 10 c.cm. F, Ninth day of illness. G, Consolidation of both bases.

CHARTS ILLUSTRATING THE EFFECT OF SERUM TREATMENT IN CASES UNDER GROUP C.

in the chest. The symptoms and physical signs presented in cases under Group C were those of lobular rather than those of lobar pneumonia; and in some cases, in addition to these, the symptoms and signs of severe capillary bronchitis with well marked cyanosis were predominant; in others the signs of severe toxaemia were well marked. Thirty-seven of our cases had definite signs of consolidation in both lungs.

Charts 3, 4, and 5 illustrate the effect of the serum treatment in these cases. In addition to the serum the ordinary routine treatment of pneumonia was also used.

being so, no time should be lost in commencing treatment with a view to preventing heart failure.

4. The timely injection of 5 c.cm. Pane's antipneumococci serum apparently retarded the development of pulmonary complications and therefore should be used as a prophylactic measure.

5. The use of the serum for this fatal form of pneumonia apparently reduces the temperature and the duration of

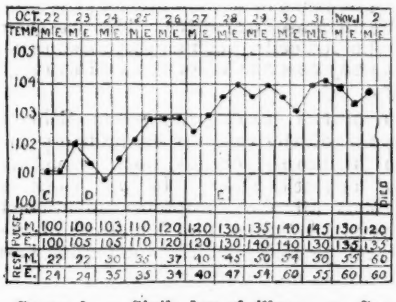


CHART 6.—C, Sixth day of illness. D, Consolidation of left base. E, Consolidation of right base.

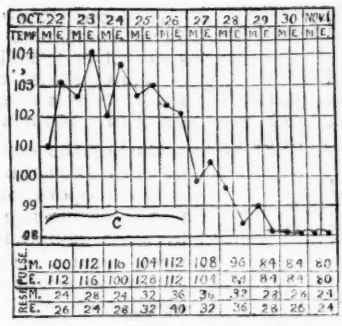


CHART 7.—C, Consolidation of right base.

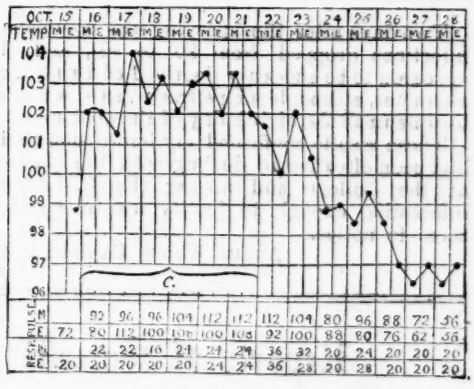


CHART 8.—C, Consolidation of right base.

CHARTS ILLUSTRATING CASES IN WHICH NO SERUM WAS USED.

Charts 6, 7, and 8 illustrate cases in which no serum was used.

In comparing the above charts it is assumed that the effects of the serum are:

1. To lessen the pyrexia; for in most of the cases it was noticed that the pyrexia was reduced by one to two degrees twelve hours after the injection, and the succeeding rise never reached the height of the previous temperature, while in cases untreated by serum the high fever was maintained and exacerbation of the previous temperature occurred on the development of a new patch.

2. Although the serum does not prevent the development of new patches of consolidation yet it seems to shorten the duration of pyrexia due to the new patch or patches, while in cases untreated by serum the duration and course of the disease is uninterrupted.

3. To prevent the occurrence of toxaemia, which only occurred in cases admitted from outside, where no serum was used.

CONCLUSIONS.

The conclusions which may be drawn from these observations are as follows:

1. That the incubation is from thirty to sixty hours, with an average of about forty-eight hours.

2. That immunity can be acquired from a previous attack or from the injection of a suitable vaccine. The duration of this immunity is certainly over three months.

3. The pulmonary complication of this influenza takes the form of a rapidly spreading bronchopneumonia; this the disease, and prevents the occurrence of other unfavourable complications.

In conclusion I wish to thank Dr. Parker and Dr. Symes for permission to publish the above cases and also for their ungrudging and most valuable advice and guidance.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ON THE USE OF FORMALIN SPRAYS IN CHECKING AN EPIDEMIC OF INFLUENZA.

In the recent epidemic of influenza among the troops at No. 1 Centre, The College, Isleworth, and among the Q.M.A.A.C. of the Hounslow, Osterley, and Isleworth area, I found that the spraying of all billets, messrooms, and canteens by a fatigue party of eight men under the charge of a non-commissioned officer appeared to be followed by an immediate check in the spread of the epidemic.

At a later date—November 4th—a severe outbreak of the epidemic occurred among the prisoners of war billeted in the rooms of a house at Ridless, Warton Road, Isleworth, and I there had an opportunity of testing this simple method of combating the disease.

The sprays, three in number, which were used twice daily from the second day of the epidemic, were Heppell's hand fly sprays with a capacity of 1¼ pints of fluid in

each. Each spray was charged with 6 drachms of 40 per cent. formaldehyde to 1¾ pints of water, making approximately a solution and vapour of 1 per cent. formalin.

After the removal of the first batch of 15 cases to hospital on the second day of the epidemic no further cases were removed to hospital until the fifth day, owing to the general shortage of accommodation in the hospitals at the time. Some of these cases in the billet were severe, but all recovered.

Table showing Daily Strength of Prisoners, Number of Cases of Pyrexia, Fresh Cases, and their Disposal.

Date.	Day of Epidemic.	Strength.	No. of Cases of Pyrexia.	Fresh Cases.	Disposal.
Nov. 4...	First	56	3	*Nil*	Kept in billet.
,, 5...	Second	56	15	12	Fifteen cases removed to hospital.
,, 6...	Third	41	20	20	Kept in billet.
,, 7...	Fourth	41	6	*Nil*	Kept in billet.
,, 8...	Fifth	41	3	1	Three cases removed to hospital.
,, 9...	Sixth	38	1	1	Kept in billet.
,, 10...	Seventh	38	2	1	Kept in billet.
,, 11...	Eighth	38	1	*Nil*	Kept in billet.
,, 12...	Ninth	38	*Nil*	*Nil*	—

Eighteen of the 56 prisoners had a normal temperature throughout.

Two days after the spraying was commenced the fresh infections dropped from 20 to *nil*, and the epidemic appeared to be suddenly deprived of its strongly infectious character, although single fresh cases occurred from time to time until the eighth day of the epidemic.

These results confirmed my impression that the method had been effective in dealing with the previous outbreak at the College and among the Q.M.A.A.C., and are interesting enough to justify me in specially bringing them to notice.

ANGUS WYLIE, Captain R.A.M.C.,
M.O. i/c Troops.

Reports of Societies.

APYREXIAL SYMPTOMS OF MALARIA.

AT a meeting of the Section of Medicine of the Royal Society of Medicine on January 28th, Major A. F. VOELCKER, R.A.M.C.(T.), being in the chair, Captain GORDON WARD read a paper with the object of providing guidance for those who may be called upon to report (1) as to whether a man shows signs of having recently had an attack of malaria; and (2) as to how far a man is disabled owing to chronic malaria the existence of which is admitted. The paper was based on observations made on over one thousand cases of soldiers under treatment in hospital after their return to France or England. It was believed that the picture of malaria seen in these circumstances was that which will be met with in civil life for some years to come. The following list of symptoms, while not professing to be exhaustive, comprised those most likely to be of value:

1. *Apyrexial Rigor.*—A typical malarial rigor with shaking and hot and sweating stages might occur with no rise of temperature. This would not be often met with, but a knowledge that it did occur might prevent mistakes.

2. *Herpes labialis* was common the day after an acute attack.

3. *Headache.*—This was frontal as a rule, sometimes occipital, almost never vertical. Temporal and frontal headache together were often seen. The patient's statement might often be verified by detecting hyperalgesia at the margins of the area in which pain was felt.

4. *Eye Signs.*—Conjunctivitis, photophobia, and nystagmoid jerking were frequent in acute attacks. In chronic cases, photophobia, pain behind the eyes, and, rarely, strabismus, were seen.

5. *Pharyngitis and Laryngitis.*—Both occurred in association with acute attacks.

6. *Jaundice.*—Some people seemed especially prone to jaundice after attacks of malaria. A slightly yellow colour was suspicious in chronic cases.

7. *Perisplenitis.*—A friction rub might be heard for three to five days over the spleen in a few cases.

8. *Pain in the Side.*—This might be due to pleural adhesions, and be felt most on deep inspiration; a course of deep breathing exercises would often dispel it. It might be due to splenic adhesions, when more complaint was made, if the patients stood for long, or took much exercise. Pain in the side might also depend on hyperalgesia of the skin or muscles, and was then at times bilateral. This was frequent in acute cases.

9. *Tremor.*—A fine tremor of the tongue and hands, rarely of the lips, was common. It might persist in chronic cases, and was then often associated with chronic headache and depression.

10. *Pigmentation.*—At times pigmentation was seen to increase with attacks and diminish between them.

11. *Tachycardia* was common when the patient first got out of bed, and might persist or only be elicited on exertion.

12. *Hyperidrosis* was not infrequent, although not often complained of. Occasionally it was so severe as to constitute a serious disability.

13. *Splenomegaly* was an uncertain sign in cases such as those under consideration. It occurred in indisputable form in severe attacks and when jaundice also was present.

14. *Transient Oedema.*—Local swellings of the nature of giant urticaria were sometimes seen on hands or legs. These lasted a few days only.

15. *Raynaud's Symptoms.*—"Dead" fingers and feet were often seen.

16. *Weakness* was often complained of, but was hard to assess. With the patient under observation it could be done by various tests, but must as a rule be a matter rather of opinion than demonstration.

17. *Blood Changes.*—The presence of the parasite was definite evidence. An increase of eosinophils and the presence of endothelial cells were suggestive. The presence of abnormalities of the red cells, such as polychromasia, anisocytosis, and megalocytosis was important, and strongly suggestive of malaria.

During the course of the ensuing discussion, Colonel ANDREW BALFOUR spoke of the relapses as probably indicating sporulation in internal organs, and agreed as to the occurrence of apyretic rigors. It was difficult to state definitely that all the symptoms mentioned were malarial in origin. A "thick film" method of examination might reveal parasites which would otherwise be missed.

Dr. F. S. LANGMEAD deprecated the common fault of ascribing all symptoms occurring in malarial districts or subjects as due to the malaria *per se*. Mere examination would sometimes reveal a secondary or independent infection. Opportunities for observation of about 10,000 cases led him to agree as to the occasional occurrence of rigors without fever, but accompanied by malaise, headache, sweating, rapid pulse, mental depression, and even vomiting. Every type of rigor occurred, from those without pyrexia up to those with the characteristic attacks. Pigmentation might be so severe as to resemble that of Addison's disease, and with this he associated cases with temporary or persistent low blood pressure and small pulse, possibly ascribable to suprarenal defect. Defective action of this gland and also of the thyroid was suggested by the tachycardia, tremor, and exophthalmos which certainly occurred. Tachycardia might be transient, abating with or soon after an attack; more persistent, but subsiding after several days or weeks; or very protracted and possibly permanent. It was difficult to say when the last two forms were indications that the malaria was merely in abeyance.

GONORRHOEA OF THE GENITO-URINARY PASSAGES.

AT a meeting of the Medical Society of London on January 27th, the President, Major A. F. VOELCKER, R.A.M.C.(T.), being in the chair, Brevet Colonel L. W. HARRISON read a paper in which were raised for discussion points connected with the abortive treatment of gonorrhoea, some details of the technique of irrigation and the attack on the gonococcus through the blood stream. Promptitude of action was of the very first importance in treatment, for all the gonococci within a urethra could be

regarded as accessible to antiseptics only on the first day of the disease. Lieut.-Colonel Raffan, A.A.M.C., had informed him that in a period of six months abortive treatment centres in this country were successful in aborting over 2,600 cases of gonorrhoea, and that he agreed with Ballenger in expecting 90 per cent. of successes when treatment commenced on the first day. His own experience had not been so successful, for the cases had not been got under treatment until the second or third day. Of 738 cases, only 129 were considered worth an attempt at aborting, and in 69 of these it failed. In 50 the disease was aborted in a week or ten days. The method now employed is as follows: (1) The parts are thoroughly disinfected with 1 in 2,000 mercury perchloride solution. (2) The urethra is irrigated with 1 in 4,000 solution of potassium permanganate, using a two-way nozzle and about two pints of solution. (3) Ten per cent. argyrol, or 5 per cent. protosil solution is injected into the urethra and retained for twenty minutes. This is repeated twice daily for three to four days, and then the silver compound is omitted, the permanganate irrigation being continued for another four to six days. When the discharge has ceased or become very scanty, and no cocci can be found in it, the treatment is omitted for a day; and if by the tenth day the urethra seems to be perfectly quiet, all treatment is stopped, and the patient told to report again in a week. If the procedure fails to abort the disease, it does not prejudice the cure. There was no question that cases treated by local remedies cleared up much quicker than if general measures were relied upon. Secondary organisms, particularly staphylococci and diphtheroid, quickly appeared, and were probably responsible for keeping up irritation. This was difficult to avoid, and unless the patients were drilled into a habit of preliminary disinfection of the glans, secondary infection of the urethra was sure to be common. After using many kinds of antiseptics for irrigation, his medical officers had settled on either one of the flavine compounds or potassium permanganate, with a weak solution of a silver compound as a variant. The results with flavine had been much the same as those with permanganate, but they were inclined to think the latter rather better. He believed in weak solutions at first, regarding all strongly astringent solutions as interfering with drainage and promoting the formation of periurethral infiltrates. He believed that the best instrument with which to irrigate the urethra was the bladder, provided that certain conditions were fulfilled. Thus, the anterior urethra should be washed first as well as possible by an anterior irrigation, and then the sphincter must be *persuaded* to open by a combination of trickery and pressure of irrigating fluid. The less pressure the better, and he preferred the vessel to be four rather than five feet above the penis.

So far no chemical agent had been found which was a specific for gonorrhoea, and we were left with the more natural method of ousting the gonococcus by increasing the antigonococcal power of the patient's tissues by vaccines. His experience of the vaccine treatment had been mixed. He concluded that the ordinary gonococcal vaccine was a poor antigen, but that occasionally one used a method or a strain which resulted in a vaccine of good antigenic power. He thought that in the complement fixation test lay the best means of testing the antigenic power of a vaccine. A vaccine prepared by Captain Thomson, made from the stroma of the organism but devoid of its toxin, was far better than any he had yet seen administered.

In the course of the discussion Captain D. THOMSON said that he had succeeded in detoxicating the vaccine, thus permitting the use of much larger dosage than had formerly been possible—for example, 10,000 millions of cocci could be injected without producing more than a slight reaction. The detoxicated vaccines were very successful in inducing the formation of antisubstances. If the complement deviation could be raised to 10 or 12 positive no cocci were obtainable from the infected source.

Captain D. LEES, speaking from the clinical point of view, said that he had compared the therapeutic results in cases treated by vaccines with those treated by mercury and subsequently by vaccines, by medicine and irrigation, by mercury alone, and by rest in bed without medicine. The cases treated by vaccine cleared up first and spent the shortest time in hospital, and were characterized by a greater moderation in symptoms, absence of complications, improvement in general condition and mental outlook, and freedom from relapses. Certain groups of cases were treated with detoxicated vaccines. These included twelve cases complicated by epididymitis, three by prostatic abscess, and two by multiple arthritis. The prostatic cases stood the treatment less well than the epididymitis cases, and showed more focal reaction; in the joint cases there was no focal reaction, and the general reaction was slight. The results were very encouraging. A series of acute cases of five to seven days' duration was then treated, and the results were very striking. By comparing the cases treated by no vaccine, by ordinary vaccine, and by detoxicated vaccine, the value of the last was made obvious, as gauged by the complement deviation, the period preceding disappearance of organisms and discharge, and the duration of stay in hospital. With this treatment local reaction was practically absent, focal reaction slight for one day, and general reaction also slight. Disappearance of cocci, discharge, and symptoms was rapid. No complications developed except slight folliculitis in one case. He was convinced that the treatment was a valuable adjunct to that usually employed.

Captain D. WATSON was in almost complete agreement with Colonel Harrison, and also favoured urethro-vesical lavage. He had given up all attempts at doing good by internal methods, and had seen cases where harm had been done by the use of vaccines. In 307 cases of acute gonorrhoea the average stay in hospital had been 26.8 days. In 222 treated by acriflavine it was 21 days; in 196 of those which were uncomplicated it averaged 19.8 days. The treatment must be continued for ten or twelve days, although the discharge ceased after three or four. The strength employed had been 1 in 4,000 acriflavine with normal saline.

Captain EDWIN DAVIS (U.S.A.), who had worked experimentally with acriflavine, considered it worthy of more thorough trial, for it inhibited growth of gonococci in 1 in 300,000 dilution, did not lose its power in urine, showed a great tendency to penetrate the tissues, and was non-toxic and non-irritating.

GYNAECOLOGICAL OPERATIONS.

A meeting of the Section of Obstetrics of the Royal Academy of Medicine in Ireland was held on January 10th, with Dr. HENRY JELLETT in the chair.

Dr. BETHEL SOLOMONS read a note on the immediate results of 500 consecutive operations for gynaecological ailments performed at Mercer's Hospital. The main conclusions arrived at were: (1) Skin disinfection is best accomplished by some reagent which hardens the skin. Ether followed by iodine is an excellent method. (2) There is less chance of pulmonary embolism if the patients are encouraged to move about freely in bed after operation. A lengthy stay in bed is inadvisable. To prevent pneumonia and pneumonitis care must be taken that the patients are warmly clad going to or coming from the theatre. (3) Curettage, when carefully performed, is a beneficial operation. (4) Of the many operations described for the cure of backward displacement, the modification of Tod Gilliam's technique described in the paper has been found to be the best. Ventral suspension and the Alexander-Adams operation have their indications, and ventral fixation is satisfactory after the menopause. (5) When it is necessary to treat sterility by operation, it is justifiable to open the abdomen to examine the state of the adnexa, even though there are no marked signs of disease. Tubes of normal size with closed ostia, hydrosalpinges, and very small cysts of the ovary are often discovered.

Dr. Solomons's paper was brought forward as a preliminary to the presentation at a later date of the more important remote effects. The percentage mortality was small, the morbidity was practically *nil*, and the after-results were excellent. In a large number of operations for the cure of sterility there were no deaths. By comparing these results with those obtained by the workers in radium and *x* rays knowledge could be gained as to which was the better.

Sir WILLIAM SMYLY said he believed in the modified Gilliam operation for backward displacement. Despite the unfortunate results which had been reported following ventral suspension, he still did the operation with satisfactory result. He did not approve of the Alexander-Adams

operation, as he liked to see the inside of the abdomen. He agreed with the main principles of Dr. Solomons's paper.

Dr. ELLA WEBB asked if the cases of pneumonia were recent and if pure ether was the anaesthetic employed. She agreed that great care must be taken to keep the patients warm in going to and coming from the theatre.

Dr. R. T. ROWLETTE said that a definite diagnosis as to malignancy in large ovarian tumours was sometimes impossible. He thought that most papillomatous tumours were malignant. He suggested that chloroform might be reintroduced as an anaesthetic when the doctors came back from France, but he did not welcome the idea.

Dr. ASHE agreed with the author of the paper that it was important to exclude the male as the cause of sterility before operating on the female.

Dr. JELLETT considered Alexander's operation the ideal for all cases of undoubtedly uncomplicated backward displacement, but that it was contraindicated in cases associated with sterility or any possible pelvic complication.

Dr. SOLOMONS, in reply, said that he had had no recent cases of pneumonia. Ether or gas and ether was the anaesthetic employed in his cases, and he would never permit the use of chloroform. He thought many women would be saved unnecessary operations for sterility if the male semen were examined.

Reviews.

GYMNASTICS FOR THE WOUNDED.

Gymnastic Treatment for Joint and Muscle Disabilities[1] is an inspiring little book. It is obvious that its author, Colonel DEANE, is himself a gymnast and an enthusiastic believer in the value of gymnastic exercises in the treatment of joint and muscle injuries. His faith is justified by the results which he has attained, some of which are described and illustrated in this book.

In a preface Colonel A. Carless calls attention to the evils following the practice of handing a patient with stiff joints over to the massage department without adequate supervision of the treatment, and without a just appreciation of the limitations of massage. Much precious time is wasted in the continuance of massage long after it should have become evident that no progress was being made. Indeed, it has sometimes occurred to us when watching the gentle stroking and stretching which too often do duty for massage and passive movement that we were witnessing magic rites rather than physico-therapeutic measures.

If the volitional muscular contractions can be called into play, the results will be infinitely greater than from passive treatment, whether it be by massage or electro-therapeutics. Colonel Deane finds that the usual equipment of a military gymnasium is enough for his purposes with a few trifling additions. Games are also of great use. A point which is well brought out is the value of associated movements, and of "the use that can be made of the man's sound limbs to enable him to recover the use of an injured one." It will probably surprise the reader to find to what an extent the ordinary climbing rope can be made useful, and what good results can be got by its use; but the most valuable piece of apparatus of all, in Colonel Deane's opinion, consists of the parallel bars—so much so that he says that, were he restricted to one apparatus, he would unhesitatingly choose this. The great value of flag signalling in forearm and elbow injuries has also been proved. The section dealing with knee troubles is of great interest, and the idea will probably be new to most readers, although it is certainly true, that in many of the exercises often prescribed the greater effect is experienced by the sound knee and leg on which the patient stands, which requires no treatment.

It is not possible in a review to give a complete impression of the teaching in this book, but we recommend every one having an interest in the subject to get a copy. Intelligent enthusiasm and appreciation of its principles should lead the reader a long way along the road which Colonel Deane has so successfully trodden out.

[1] *Gymnastic Treatment for Joint and Muscle Disabilities.* By Brevet Colonel H. E. Deane, R.A.M.C. London: Henry Frowde, and Hodder and Stoughton. 1918. (Cr. 8vo, pp. 146; 26 figures. 5s. net.)

MUIR AND RITCHIE'S "BACTERIOLOGY."

WE welcome the appearance of the seventh edition of MUIR and RITCHIE'S well known *Manual of Bacteriology*,[2] which we take to be the best textbook of the subject for students or medical practitioners in any of the civilized—or, for the matter of that, uncivilized also—languages in Europe. Since the previous edition appeared bacteriology has learned a great deal from the war, as is shown by the chapters dealing with tetanus, cerebro-spinal fever, the infection of wounds with anaërobic bacteria, and various intestinal infections. Infectious jaundice due to spirochaetes, and trench fever, whose etiology seems to be in the way of settlement, are also war diseases that receive extensive notice in the volume.

The book does not contain a chapter on the filter-passing virus, but the subject is referred to in the articles on small-pox, rabies, and epidemic poliomyelitis. The authors—wisely, no doubt—do not commit themselves to any definite opinion. The investigation of the subject, however, appears to be making so much progress that even though, as we expect, the eighth edition of the manual may shortly be called for, it will probably be found desirable to deal with the matter at length in it.

The seventh edition now before us has been enriched by the addition of new methods and a number of new illustrations. The authors are to be congratulated on the skill with which they have condensed the best part of the science of medical bacteriology into a well written and readable handbook, which may fairly be regarded as indispensable to the bacteriologist, the pathologist, and the student of medicine.

MILK HYGIENE.

IN his *Principles and Practice of Milk Hygiene*[3] Professor Louis A. KLEIN of Philadelphia has succeeded in presenting in concise form the facts and principles which are of importance in the practice of milk hygiene and in describing how they may be applied in the inspection of dairy farms and in the examination of milk. The subject is one in which physiology, chemistry, bacteriology, and sanitary administration are intimately interwoven; it is surveyed by the author in a very fair perspective. American cities have for some years graded their milk supplies into classes, and Professor Klein gives a very full account of the standards that have been employed, including the report for 1917 of the commission on milk standards appointed by the New York Milk Committee; in this report the commission recommend that the bacterial limit for Grade A raw milk should be reduced from 100,000 to 10,000 bacteria per c.cm. The book is the work of a veterinary surgeon, and as such deals in a thoroughly practical manner with all the problems that confront sanitary officials, social workers, and all persons interested in the production of wholesome milk. It is a volume which should be on the bookshelf of every up-to-date farmer, public health official, and lecturer. The paper, print, and illustrations, as well as the subject matter itself, are such that the book can be read with interest and pleasure.

In an excellent little manual, entitled the *Pasteurization of Milk*,[4] C. H. KILBOURNE, late chief of the division of pasteurizing plants in the New York City Department of Health, treats the subject from the practical standpoint. He has had experience of the use of the different forms of plants for pasteurizing, cooling, and storing milk; he gives a description of them and discusses their efficiency. All concerned with the installation and control of such apparatus will find information in this book which will assist them in making the system safe in practice, for which intelligent supervision is essential.

[2] *Manual of Bacteriology.* By Robert Muir, M.A., M.D., Sc.D., F.R.S., and James Ritchie, M.A., M.D., F.R.C.P.Edin. Seventh edition. London: H. Frowde, and Hodder and Stoughton. 1919. (Cr. 8vo, pp. xxiv + 753; 200 figures, 6 coloured plates. 16s. net.)

[3] *Principles and Practice of Milk Hygiene.* By Louis A. Klein, V.M.D., Professor of Pharmacology and Veterinary Hygiene, School of Veterinary Medicine, University of Pennsylvania. Philadelphia and London: J. B. Lippincott and Co. 1918. (Med. 8vo, pp. x + 329; 41 figures. 12s. 6d. net.)

[4] *The Pasteurization of Milk from the Practical Viewpoint.* By Charles H. Kilbourne. New York: John Wiley and Sons. London: Chapman and Hall, Ltd. 1916. (Fcap. 8vo, pp. iv + 248; 34 figures. 6s. net.)

NOTES ON BOOKS.

CAPTAIN GARTON'S little book on *Electro-Therapeutics for Military Hospitals*,[5] written to satisfy a need that one hopes will not much longer press on us, gives a brief but practical account of simple methods of treating paralysis, neuritis, trench feet, and the like by electrical methods. It may be recommended to those in search of an elementary account of the subject.

Dr. LARRIEU[6] holds that pulmonary tuberculosis is a disease very largely amenable to treatment by drugs, and recommends, in a long pamphlet on the subject, the exhibition of a mixture containing potassium iodide, potassium bromide, and strychnine as its most important constituents. Other drugs are prescribed to meet special emergencies; for the rest, the treatment is on general and hygienic lines. The book may be read in a critical spirit by medical men interested in the treatment of the disease.

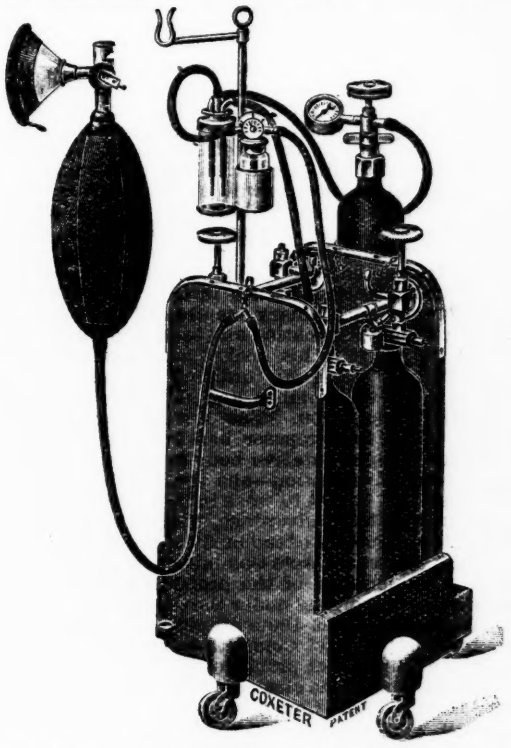
[5] *Electro-Therapeutics for Military Hospitals.* By Wilfrid Garton, M.R.C.S., L.R.C.P. London: H. K. Lewis and Co., Ltd. 1917. (Cr. 8vo, pp. viii + 48. 2s. 6d. net.)

[6] *Traitement efficace et pratique de la tuberculose pulmonaire.* Par Dr. J. F. Larrieu, Lauréat de l'Académie de Médecine et de la Faculté de Paris, etc. Paris: Vigot Frères. Petrograde: Ch. Ricker. 1918. (Demy 8vo, pp. xvi + 96.)

MEDICAL AND SURGICAL APPLIANCES.

Nitrous oxide–Oxygen–Ether Outfit.

CAPTAIN H. EDMUND G. BOYLE, R.A.M.C.(T.F.), Anaesthetist to St. Bartholomew's Hospital, writes: The accompanying figure shows one of the patterns (*b*) of the above machine. The main points are: each cylinder



is provided with a fine adjustment reducing valve (the valves can be fitted to any ordinary English cylinder); the principle of the "sight feed" has been adopted; there is a small spirit lamp for warming the reducing valve to the nitrous oxide cylinder; a pressure gauge is attached to the oxygen cylinder; a small rebreathing bag is attached, together with an ordinary 3-way stopcock and face-piece; an ether bottle is connected up in the circuit. The machine has been made in three sizes: (*a*) The large size is for work abroad; when fully charged it takes four cylinders of 200 gallons, two of 500 gallons, and one of 40 ft. capacity for oxygen. (*b*) The next size is meant for work in hospitals at home, and carries four cylinders of nitrous oxide of 200 gallons each, and a 20 ft. cylinder of oxygen. (*c*) The size for private practice takes four cylinders of 100 gallons, two of nitrous oxide, and two of oxygen. Cylinders of 25 or 50 gallons capacity can be used with this pattern; the stand carrying the "sight feed" bottle and the ether bottle can easily be dismounted and securely stowed away between the cylinders; and there is a covering lid and carrying handle. Types (*a*) and (*b*) are on wheels.

These machines are economical in consumption of gas. Eighty gallons of nitrous oxide and 20 gallons of oxygen are usually enough for one hour's continuous anaesthesia. I have now completed over 2,000 administrations with this method, and am able to record over 1,600 administrations by Captain J. F. Trewby and the residents at the 1st London General Hospital, making a total of over 3,600 cases, without any fatality. I desire to thank Captain Geoffrey Marshall, R.A.M.C., for many valuable suggestions with regard to the use of this machine in France.

REPRESENTATION OF THE MEDICAL PROFESSION.

"MASS MEETING" IN LONDON.

WHAT was described as a "mass meeting" of the profession was held at Wigmore Hall on Sunday afternoon, February 2nd. The conveners were the Council of the National Medical Union, and about three hundred were present. The proceedings lasted three and a half hours and were constantly interrupted. Dr. R. FIELDING-OULD, who took the chair, stated that the presence of any member of the profession on the platform must not be taken to mean that he was committed to the official resolutions.

The resolutions on the agenda were two, namely:

1. That in view of the prospective legislation and the proposed establishment of a Ministry of Health, and having regard to the experience of the medical profession at the time of the passing of the National Insurance Acts, the time has arrived when a body representative of the whole profession should be established to watch its interests and be prepared to act in an advisory capacity as occasion demands.
2. That a provisional committee be now formed with the object of securing the election of such a body.

The second resolution, however, though proposed and seconded, was never put to the meeting.

The CHAIRMAN apologized for the absence, owing to ill health and the severity of the weather, of Dr. William Russell of Edinburgh, who had been announced to take the chair. He went on to say that those who had taken the initiative in calling that meeting had always maintained the principle that unity of the profession was the thing to strive after. While they had no wish to compete with any existing body, they felt that steps should be taken at this serious juncture to enable the mass of general practitioners to express their views, to advise, and, if necessary, to criticize the Government on questions of importance to the national health. There had long been a deep-rooted prejudice in the medical profession against taking part in political movements, but in an advancing democracy with socialistic tendencies, for the great body of medical men to stand aloof would be fatal not only to the profession but to the interests of national health. The great mass of general practitioners must be heard, but at present there was no representative body to focus their views. The question was urgent. At that moment there was a small self-constituted body called the Medical Conference dealing with the Government—dealing with the interests of medical men. Had any one heard of it? (Cries of "No.") That was the kind of thing they who had called that meeting wished to stop.

Dr. V. T. GREENYER, in moving the first resolution, said that the medical profession was divided into two classes, the active medico-political and the non-active. The former had by this time crystallized themselves into different bodies. There had been experience of an Association which, according to the best of its knowledge, had adopted a measure of representation that in the past had been successful to a certain extent. It was questionable, however, whether that method was sufficient for the future. Among other medico-political bodies, in addition to the British Medical Association, were the Medico-Political Union, the National Medical Union, the Association of Medical Women, and the body that was the outcome of the meeting on October 1st last at Steinway Hall. These bodies would form schools for the future training of medico-political members of the profession. The only way in which a proper representation could be secured was by the education of the particular man chosen to be a representative. The great peril in medico-political activity lay in the difficulty of distinguishing between the men who had axes to grind and those who had not. The British Medical Association had sacrificed the confidence of the profession. (Prolonged applause and some dissent.) Personally he could not forget the January of 1913. The rank and file of the profession had had to bear the ignominy of that great *débâcle*. Between 1906 and 1913

the British Medical Association was a body that all admired. Its pitch of organization was high. It could look back to many glorious annual meetings, when representatives of the whole world of medicine met in harmony. Those were splendid days; when the Association held the entire confidence of the profession. But the Association sacrificed its opportunity, and then it said the rank and file had done it. What happened was that the confidence of the rank and file of the profession was such that they obeyed those secret orders which came down to them, "Come on to the panel or you will be ruined." Now the rank and file of the profession had allowed things to die down. But had there been any attempt to restore the confidence? If not, the time had arrived when a representative body should be formed. The National Medical Union stood by the resolution which, he believed, had not been rescinded from the minutes of the British Medical Association, that the working of the Insurance Act was derogatory. But the Union possessed neither the machinery nor the brains to justify it in coming forward as representing the medical profession, nor was it anxious for that position. The Medico-Political Union had taken up what it considered to be an advanced position, but the profession was not at one with regard to trade unionism. He could wish that the Union was a little more humble, but it was an excellent union, though not capable of representing the profession as a whole. Above all things, a body was needed to protect the economic side of the profession.

Dr. G. P. JOY, in seconding the resolution, said that the Government of this country in 1913 was guilty of an abuse of power in forcing a sufficient number of medical men to work the National Insurance Act. This was done in despite of the sound instincts of the profession, which strongly condemned the conditions of service. At the present moment the tendency was to underrate the profession as a fighting force, and it was in danger of being driven where the politicians and place-hunters chose. Medical men had not had justice from the State because they had lacked cohesion. The remedy was strong, straight leadership. Their hope of securing this lay in the creation of a body of chosen representatives to voice the aspirations, the needs, and the will of the profession. The immediate problem was to determine how best to make the voice of the profession heard.

Dr. EDWIN SMITH, in supporting the resolution, entered into detail, which called forth impatient interruptions from the audience, with regard to the reduction of the notification fee for infectious diseases from 2s. 6d. to 1s.

Sir WATSON CHEYNE, M.P., said he was not going to speak on politics. The question was whether it was right that some representative body should be formed to look after the medical affairs of the nation. He suggested that for the sake of peace and quietness the reference to the Insurance Acts might be dropped out of the resolution. It was done with, and they had got to put up with it. (Loud cries of "No.") There were various reasons why medical practitioners were not sufficiently represented in the affairs of the nation. Most of the medico-political bodies had gone wrong by thinking of minor matters and not of what was best for the nation—because, after all, what was best for the nation was in the long run best for the profession. Then there was the tendency to trade unionism; that would not go down at all. ("Oh!") They were above trade unionism. (A voice: "What is the alternative?") He was not going to argue it; he was only telling them. (Laughter.) The first remedy suggested was to get more medical men in Parliament. That was all very well if the medical men in Parliament all thought in the same way. It was not so much a question of getting more medical men into Parliament as of informing and uniting those who were there. He had been in Parliament for eighteen months, and it had fallen on his shoulders to try to raise by such parliamentary action as he could the level of the medical profession. He had done his best, but he could have done better if he had had some body at his back from whom he could get particulars as to different kinds of practices and working conditions. A body was wanted to train up medical members of Parliament in the way they ought to go. He was uncertain many a time whether he ought to interfere when a bill came forward embodying a medical matter. The British Medical Association had helped him very much, though from the tone of the meeting it might be thought that it gave no help at all. But at the same time he was not a delegate for the Association, and he would like to get a rather bigger view than the Association's. Much that had been said against the Association that day was rather unjust. He himself resigned his membership of the Association some years ago on account of its tendency to trade unionism. But it was one of the bodies that took rather a parochial view. He had suggested at Steinway Hall what he was suggesting that day, and he was glad to know that the idea had grown, and that the Medical Parliamentary Committee had taken it in hand, had proceeded to co opt members from different bodies, totalling a greater number than the original members, and he hoped that in time it would represent every side of the profession.

Major E. R. FOTHERGILL said that the *débâcle* of 1913 was not caused by the British Medical Association, but by the scum of the profession who went behind their brethren to try to come to terms. (Interruption.) A committee was already in existence, had been in touch with Dr. Addison, had seen the drafts of his bill, was consulted by him before he first introduced the bill, and had itself consulted the profession through the Divisions of the British Medical Association. This body had been in existence for eighteen months. Would that meeting, instead of setting up a new body, not do better to transfer its support to a body already existing? Had the British Medical Association waited until now they might certainly have condemned it, but it had been at work on the question of the forthcoming legislation, actively for two years, and passively for thirty years before that. Was the profession to waste time in forming a new body to start *de novo*, when it was open to it to stimulate an existing body and see that it did its work?

Dr. H. B. BRACKENBURY hoped the meeting would negative the resolution, not because there was anything illogical or improper in its wording, but simply because of the way in which it had been put to the meeting. The gist of the proposition was that there were several antagonistic bodies within the profession, and therefore they must proceed to form another. The better way of proceeding would be to find out whether there was among these bodies any one which represented a considerable proportion of the profession, which had a decent history, which had acquired some influence, and which could be made a proper body to represent them. They could never have a body representative of the whole profession. There were large numbers of the profession who would never join any body at all. Beyond this, they must always have in medical politics, as well as in scientific subjects, antagonistic views which would remain antagonistic. The ideal was to have some arrangement by which the great central body of opinion should be represented as largely as possible. He agreed that the British Medical Association made several gigantic mistakes in 1913. Up to that year he himself was an ordinary member of the Association. He wrote out his resignation and took it to the pillar-box, and then he put it in his pocket again, and determined that instead of being an ordinary member he would become an active member and do what he could to improve the Association. The remedy for the state of affairs to which the proposer had alluded was surely to take the most representative body in the profession—the British Medical Association—and see whether these other bodies could not be got to work in harmony with it. The Association had this advantage, that it contained more than half the members of the medical profession, and that through its Insurance Acts Committee it represented the whole of the members of the profession—fourteen thousand—who were working under the Insurance Acts. (No.) It might not represent them properly, but it represented them, for all the Panel Committees of the country were elected by all the panel practitioners of the country, and those Panel Committees elected a majority of the members of the Insurance Acts Committee.

Mr. E. B. TURNER said that to start another body would be to help to disunite the profession. That would be to play into the hands of the enemy, by which he meant the Government. Furthermore, the setting up of a new committee would be no effective step so far as the proposed legislation was concerned. The Ministry of Health Bill was in draft; it would go through the House in a hurry, and the immediate thing to do was to see that on the committees which were advisory to the Minister there was proper representation of the profession. He considered that he himself represented a very large number of persons because he was elected to the Council of the British Medical Association from the Annual Representative Meeting. He was certain that the best thing that the meeting could do would be to make that its representative body; if it wanted to alter it there were voters enough present to affect the London representation. He urged that the organization of the Association be used—its Divisions, its money, its name, and its influence with the Government.

Captain GUEST strongly protested against what he called the insulting remark of Major Fothergill with regard to the scum of the profession. That remark should be apologized

for. What he really meant was not the scum of the profession, but the men in the profession who were poor, and it was not fair in any meeting of professional men and women that their brethren should be sneered at who were poor. Speaking as a Labour candidate at the last election he declared that there would never be any organization worth anything unless it started on the basis of organizing the means of livelihood of the profession. The first plank of any organization must be a decent living wage for all men in that profession. The British Medical Association failed because it had no funds to protect its members against victimization. The organization to be set up must have a fund to protect members of the profession against victimization, and it must be prepared if necessary to use the trade union weapon of the strike. (Applause.)

Dr. C. F. T. SCOTT declared that it was Sir Watson Cheyne who was parochial and not the British Medical Association; he had proved himself so parochial as to withdraw from it. The British Medical Association had the means of giving effective force to the views of the profession, and if all joined the Association the profession would know exactly where it stood. He believed that the Association had learnt its lesson.

Dr. GREENYER, in replying to the discussion, said that he and those associated with him were taking this action because they realized that the so-called scum of the profession had not hitherto found representation. That was the very reason why he asked for representation for the various bodies he had mentioned in his opening remarks. (Laughter.) He disclaimed antagonism to the British Medical Association, and said they hoped to include representatives from that body.

A division on the first resolution then took place, when there voted:

In favour	182
Against	93

The second resolution, setting up a provisional committee with the object of securing the election of a body representative of the whole profession, was then formally proposed by Dr. EDWIN SMITH and seconded by Dr. A. MORISON.

Dr. SQUIRE SPRIGGE moved an amendment:

> That this meeting of the medical profession, in view of the urgency arising from contemplated legislation, approves the recognition of the Medical Parliamentary Committee as a provisional committee, and that that Committee should be entrusted with drawing up the constitution of a body to develop along the indicated lines.

He said that the adjectives used already in describing what qualifications the ideal body must possess embarrassed him in putting forward this amendment, for he was not certain that the Medical Parliamentary Committee possessed all the desiderata. The pith of the amendment was in the words, "the urgency arising from contemplated legislation." The meeting had been told that the draft bill in Dr. Addison's hands was going to be one of the very first measures pressed forward by Parliament. At the present moment, of twenty-one names of members of the Medical Parliamentary Committee put before him, fourteen represented general practitioners. The whole idea of the Medical Parliamentary Committee, as it had been conceived and since worked, was that the general practitioner should be consulted, and that his views, and those of other sections of the profession, should be adequately represented and placed before the medical members of Parliament, who in their turn promised to act along the indications given. If the committee had enough flexibility of organization to become the nucleus of a body representative of the whole profession, then it had every opportunity of placing before members of Parliament representative views on matters affecting the profession. Such a committee ought to be really inclusive, and in that event a good deal of the present differences would disappear on frank discussion, and a *modus vivendi* would become obtainable. He could conceive of a really strong Parliamentary Committee being very educational, in the first place of itself, and then of the profession, of members of Parliament, and of the nation, though not, perhaps, in quite that order. He did not ask the meeting to accept the committee as it was, but only as the nucleus of what it might and ought to be. He absolutely dissociated himself from the virulent attacks upon the British Medical Association. He knew the good that the Association had done, he was not blind to its mistakes, and for some of those mistakes he saw the reason, while others had caused him bewilderment. And the strongest argument he could bring forward in favour of constituting the Parliamentary Committee as the nucleus of the desired organization fell from Major Fothergill's lips when he said that they wanted a body to "ginger" up the British Medical Association.

Dr. ARTHUR LATHAM, in seconding the amendment, said that the Committee was temporary, and had no desire to be permanent. It was formed as the outcome of the open meeting on October 1st. It consisted now of thirty-five members. A number of representative bodies had been asked to nominate delegates to sit on the Committee, and it had been more successful in getting responses to this invitation than, he thought, any other body of the kind. Twelve organizations in the profession had appointed delegates. The British Medical Association and the Royal Colleges had been asked to send delegates, but hitherto they had declined; perhaps they did not thoroughly realize the objective in view. The Committee gave help to medical men who were candidates at the last election. It had secured the sympathetic help of one of the most keen and educated lobbyists in the House of Commons. It had always had a good reception from Dr. Addison, and had obtained from the Prime Minister a promise to receive a deputation as soon as he was free. If appointed to act upon the decision of the meeting that day it was intended to draw up a scheme which would be submitted to the profession as a whole.

Dr. C. BUTTAR read the names of the Medical Parliamentary Committee in response to a demand from the audience. At the end of his recital of the names, Dr. Buttar was asked from several parts of the hall, "Who elected them?"

Dr. C. O. HAWTHORNE said that this amendment raised a serious question. The meeting had been summoned for the purpose of passing a resolution to establish a new representative body, and when this general resolution was carried there was moved and seconded from the platform in a purely formal manner a further resolution that a committee be constituted. Thereupon, also from the platform, this amendment was moved and seconded.

The CHAIRMAN pointed out that a seat on the platform committed no gentleman to support of the original resolutions.

Dr. HAWTHORNE thought it very significant that the second resolution was only moved formally.

Dr. EDWIN SMITH, the mover of the resolution, showed the notes of the speech he had prepared in support of the resolution. His determination to move it formally was due to the lateness of the hour.

Dr. HAWTHORNE still felt a suspicion that the meeting was organized, not with a view to forming a new body, but to supporting the Medical Parliamentary Committee.

The CHAIRMAN denied that there was any collusion.

Dr. HAWTHORNE said that the fact remained that the meeting had passed a resolution to constitute a new body, and was now asked to transfer its benediction to an organization already existing. He intended, further, to vote against this amendment because of the way the Medical Parliamentary Committee was constituted. (Hear, hear.) It was charged with the duty of reporting to the profession some scheme by means of which the election of medical men to the House of Commons could be secured. It had not made a report to the profession. While the Committee had recommended candidates for the last election, it had carefully abstained from recommending any constituency to elect them.

Dr. E. G. NEWELL, a member of the Medico-Political Union, criticized the validity of the election and the representative character of the Committee.

Dr. J. G. FITZGERALD suggested, amid great interruption, that nine-tenths of the members of the Medical Parliamentary Committee were members of the British Medical Association.

Dr. LATHAM, in a personal explanation, denied that there was collusion between the Parliamentary Committee and the organizers of that gathering. The Committee knew nothing of the meeting until it was announced in the press.

The amendment recognizing the Medical Parliamentary Committee as the provisional committee to carry out the terms of the first resolution was then put and lost. There voted:

In favour	87
Against	105

Dr. J. A. ANGUS then moved:

> That in the opinion of this meeting no committee or organization of medical men is capable of effectively representing the interests of the profession unless it is a registered medical trade union.

He said that it was evident from the temper of the meeting that the idea of a trade union was making great headway. The medical profession had been denied and flouted continually. The British Medical Association had done much,

but that much could only be little because it was not a trade union, and could not use its funds for trade union propaganda, or for the support of the men who obeyed its behests. No committee would have effective means of forcing their views upon the Government. In every constituency a medico-political association must be instituted.

Dr. NEWELL seconded the amendment.

Major W. A. CHAPPLE thought it rather dangerous to follow Dr. Angus's line of argument. Trade unions were effective because they had the numbers and because their weapon was the strike. Were medical men prepared to use that weapon? (Cries of "Yes.") If all other methods failed, the medical profession might be driven into that position, but meanwhile he thought they could depend much more upon the righteousness of their cause—— (The remainder of the sentence was lost in uproar.)

Dr. A. MORISON, who also spoke amid interruption, the Chairman having several times to appeal for order, asked whether such ideals as had been voiced by Dr. Angus were those which ought to inspire a liberal profession. Such a policy, followed out to the end, would bring the bear-garden they deserved.

A division on the amendment was then taken and there voted:

In favour of Dr. Angus's amendment ..	71
Against	73

The announcement of the figures was received with vociferous demands for a recount, which the Chairman refused because in the interval some members had left the meeting. Dr. Angus declared that only two members had left, and repeated his demand for a recount, amid great disturbance. Mr. E. B. Turner, Dr. Greenyer, and others attempted to speak, but failed to get a hearing, and the Chairman persisting in his refusal to grant a recount, and the noise continuing, he left the chair, and the meeting broke up.

THE MINISTRY OF HEALTH.

DEMONSTRATION IN LONDON.

A DEMONSTRATION in support of the early establishment of the Ministry of Health was held in Kingsway Hall, London, on February 3rd, the eve of the opening of Parliament. Sir KINGSLEY WOOD, M.P., presided over a large gathering, and was supported by Dr. Addison, President of the Local Government Board, the Viscountess Rhondda, Sir Bertrand Dawson, and several members of Parliament and prominent medical men.

The CHAIRMAN read a message from the Prime Minister, who wished the meeting every success and expressed his belief in the object which the meeting had in view.

Dr. ADDISON, who spoke for the first time as the holder of his present office, began by paying a tribute to Lord Rhondda, dwelling upon his enthusiasm in this matter, his clearness of vision, and his determination. There could be no worthier memorial to Lord Rhondda than the rapid passage of the bill through Parliament. Dr. Addison said that he took his office on the understanding that this bill was going to be passed through as rapidly as possible. Holding up a large placard, he said that he intended to publish it as a Parliamentary White Paper; it was a record of the twenty-one Government departments, and the more than two thousand local authorities at present doing odds and ends of health work. That was a justification for a co-ordinating Ministry. He could name certain public services of the most essential character which had been delayed for years from coming into full activity in consequence of quite genuine departmental disputations; and with two thousand local authorities, with their overlapping areas and interests, it was evident that the divided counsels, the disconnected effort, and the various rivalries which existed at the centre would be reflected all over the country. The first step in the new proposals was to create a Ministry; the second was to formulate its programme, for the Ministry was not an end, but only an instrument. He had no doubt that the proposals would be welcomed, but they would need all the help and goodwill of the local authorities, the insurance organizations, and the medical and nursing services, because, if a rational scheme was to mature, it must be on comprehensive lines, and inevitably this would not please everybody who was engaged in administration. Great measures might be held up, not by departmental entanglements at head quarters, but by local differences, and he appealed, therefore, to local administrators to "lift their eyes above the nozzle of the parish pump." The proposals of the bill were familiar, and he anticipated few changes during its passage. The governing consideration was that they must have a body of men upon whom they could fix responsibility, and then it would be the business of those men to formulate a programme. A feature of the bill which had given rise to more difficulty than any other was the setting up of an advisory council. It was necessary to devise machinery whereby professional and public opinion would make its influence felt in the moulding of policies, and he was determined that the advisory council should be a reality. He was not afraid of any minister staffing such a council with Bolshevists; often these outside people acted as a drag upon the wheel of a too enthusiastic minister. The provision of skilled, well-trained, and properly paid nurses and midwives, and the organization of facilities for diagnosis, were essential parts of the measure. He received half a dozen letters a day from medical men asking whether a State medical service was to be instituted. Nobody need be alarmed. The Government had to make use of every branch of the existing service, and the traditions of the medical profession or of the British public were not to be uprooted by any edict a Ministry of Health might issue. He thought it possible to provide the necessary services—with laboratory, clinical and nursing facilities—without detriment to the susceptibilities or proper ambitions of any one. The keynote would be prevention, and in this connexion the responsibility for housing must attach to the Ministry of Health. He proposed to ask for authority to deal in a common-sense way with restricting by-laws and other limiting arrangements. He added that the Ministry would not propose to proceed by compulsion. The people only needed to have practical schemes put before them to enlist their support.

Lady RHONDDA pleaded that, in addition to the other advisory councils, a council composed of ordinary wives and mothers should be established in connexion with the Ministry, both to learn and to advise, and to act as a link with the homes of the country.

Sir BERTRAND DAWSON said that the doctor was a vital part of the structure which had to be built. It was most important to train the general practitioner and give him opportunity for doing his best work. It was of some importance, since the interests of the public and of the doctors were really identical, to know what was the attitude of the medical profession towards this movement. The attitude was one of hearty sympathy as to the aims of the new Ministry, but as to the methods it was one of watchfulness tinged by doubt. The reasons were not far to seek. Medical men, like other citizens, left their all to go to the war, and they had now come back and were faced with the task of building up their practices afresh. It was necessary to think of the doctor's years of apprenticeship, of his struggles while fighting his way up, of his round of busy days and disturbed nights; and it was little wonder if he hesitated over any scheme which might possibly make his working conditions more difficult. Furthermore, each year the work of medicine became more complex and required larger equipment. The doctor also wanted greater freedom from lay control. The principle of medical guidance in medical affairs had already been recognized by the President of the Local Government Board in introducing the bill last session. Proceeding to the more public aspects of the question, Sir Bertrand said that the real test of success of the policy of a Ministry of Health would lie with the local communities—the counties and boroughs. And just as they had fabric and equipment provided for education in the shape of the school, so they would need to bring together all their activities in the health centre. By such united effort they would not only make for working efficiency, but would form a school of thought and encouragement and public spirit. By bringing together the preventive and curative parts of medicine an end would also be put to an artificial separation. In his opinion the health centre could go a step further; they wanted something in the centre which would convey the idea of health in its active rather than in its passive conception. Health denoted vitality, endurance, and joy, and that must be provided for in the organization. He suggested the provision of open spaces in connexion with the clinics where physical culture and games could be carried on.

A resolution was carried, on the proposition of Sir ALFRED WARREN, M.P., seconded by Mr. W. A. APPLETON, secretary of the General Federation of Trades Unions, calling upon the Government to give early facilities for passing the measure, and also to incorporate in the bill a definite declaration that the non-medical side of the Poor Law and other non-health functions should be dissociated at an early date from the Health Ministry.

British Medical Journal.

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THE TREATMENT OF WOUND SHOCK.

THE publication in full of Professor Bayliss's lectures on the treatment of wound shock serves as a reminder of the part played in the war by the science of physiology. In all phases of the common activity of the nation evoked by this supreme struggle, the solution of difficulties and the adaptation necessary to ensure success have commonly been provided in the first place, not by the so-called practical man, but by the laboratory worker. It is true that the accusation of scientific aloofness, which in the past has frequently been brought against physiology in this country, has been due in the main to a failure to appreciate the constant and growing influence exercised on the practice of medicine by every addition to our knowledge of the normal workings of the healthy body. It is true also that the part played by physiology in the war is still too scantily recognized, though it has ranged from the preservation of the aviator to the regulation of food, from gas defence and treatment of gas poisoning to the prevention of scurvy among the troops. The researches, of which an account is given in the volume entitled *Intravenous Injection in Wound Shock*,[1] carried out by the most learned physiologist of the day, and belonging to a subject hardly mentioned in the text-books of ten years ago, have at last not only thrown light on the long-disputed nature and causation of wound shock, but have placed in the surgeon's hands an effective method of treatment and prevention.

An abstract, obligingly furnished by the author himself, of the two lectures given under the Oliver-Sharpey foundation, before the Royal College of Physicians, in May, 1918, was published in our columns at the time.[2] The book before us gives the substance of the lectures at greater length and includes some further evidence as to the nature of shock, derived from experiments performed subsequent to their delivery. Professor Bayliss deals in the first place with the relation of shock to haemorrhage. He shows that in shock, as in haemorrhage, the essential feature is a deficiency of blood in circulation. In most cases, in fact, shock is complicated with haemorrhage of more or less gravity, but in every case the treatment is the same—namely, the restoration so far as possible of the volume of the circulating fluid, so that the circulation may be maintained and the supply of oxygen to the tissues kept up.

Since every rational therapeutic must depend on the knowledge of the causation of the condition which it is desired to ameliorate, the author has to discuss the essential nature of wound shock. He shows that dilatation of the vessels or vasomotor paralysis is not an essential feature, and that acidosis or diminution of the alkaline reserve of the blood, which is almost invariably present in the later stages of shock, is more of the nature of a result than a cause, and is due to the starvation of the tissues in oxygen consequent on the augmenting failure of the vascular supply. He concludes that in the absence of haemorrhage the fall of blood pressure and the diminution of the fluid in circulation must be due to a general capillary dilatation and to the loss of blood from the circulation by stagnation in this part of the system. He adduces certain facts which appear to indicate that this capillary dilatation is toxic in origin, and is due, perhaps, among other factors, to the absorption of chemical substances produced in damaged muscle. Dale has shown that a condition indistinguishable from wound shock can be produced by the injection of histamine, and that the salient feature of the action of this drug is a dilatation of the capillaries, which may be combined with constriction of the arterioles. Whether the substance absorbed from the injured tissues is histamine itself, or some other body presenting similar physiological properties, has not yet been definitely established.

The essential feature of shock being the loss of fluid from the circulation, the obvious method of treatment would be the introduction of fluid to make good this loss. Salt solutions, isotonic or hypertonic, are useless for this purpose, since they escape through the capillary walls almost as rapidly as they are injected. Alkaline salt solutions are equally ineffective, and may, in fact, be harmful. Human blood may, of course, be used, and has been used to a large extent in France, provided that a giver is at hand and that it is possible to take all the precautions necessary for the transfusion of blood from arm to arm, or the injection of blood preserved by citration and exposure to cold. Professor Bayliss shows that these complications are unnecessary, since equally good results can be obtained by the injection of an artificial serum, which can be prepared and maintained sterile in any quantity. Salt solution escapes from the vascular system owing to its deficiency in protein, so that it has neither the viscosity of serum nor the osmotic pressure due to the protein which serves to keep the water of the blood within the vessels. It was necessary, therefore, to find some substance or substances which, added to salt solution, will confer on this fluid a viscosity and a colloidal osmotic pressure equal to that of blood or blood serum. These requirements, Bayliss shows, are met by two substances—namely, gelatine and gum arabic. Gelatine presents the disadvantage that it may contain tetanus spores, that it tends to be altered by effective sterilization, and that it may promote intravascular clotting. None of these disadvantages are possessed by gum arabic. A solution of gum arabic of 6 per cent. or 7 per cent. in 0.9 sodium chloride has the viscosity of blood and the osmotic pressure of its colloids. Gum arabic is quite innocuous both in animals and in man. It is easily sterilized without loss of viscosity, and its repeated injection does not give rise to anaphylactic phenomena. It does not haemolyze or agglutinate human blood. The gum salt solution, previously sterilized and filtered, can be preserved in well closed bottles which can be used even in the advanced dressing stations.

When a patient shows signs of shock with the customary lowering of blood pressure, Professor Bayliss recommends that this gum salt solution be injected in quantities sufficient to raise the blood pressure to a normal level. A certain number of illustrative cases are quoted in the lectures showing the excellent results obtained by this procedure. Many patients were saved who without the injection would certainly have died of the original injury or of the necessary subsequent operation.

It is interesting to note that Bayliss's discovery has not failed of appreciation by the German medical service, who, however, following a practice long established in that country, ascribe the use of gum arabic to a certain physiologist, Kestner, whose fame

[1] London: Longmans, Green and Co. 9s. net.
[2] BRITISH MEDICAL JOURNAL. May 18th. 1918. p. 553.

has not yet reached this country in connexion with any other physiological discoveries. In this connexion the author reminds us of the fact that Christopher Wren was "the first author of the noble anatomical experiment of injecting liquors into the veins of animals, now vulgarly known, but long since exhibited to the meetings at Oxford and thence carried by some Germans and published abroad."[8] It is apparently not easy to eradicate national habits.

THE OVERFULL MEDICAL CURRICULUM.

IN discussing recently schemes on foot for a reform of medical education we made the observation that the difficulty of every reformer of medical education has been so to adjust his scheme that the average man may enter upon his life work at a reasonably early age. The point was well put by Dr. Peter Mere Latham in a lecture he delivered at St. Bartholomew's Hospital over eighty years ago. "If all medical students," he said, "had fifteen or twenty years at their disposal, and could dedicate them all to professional education, we might pardon a little innocent declamation in displaying the rich and varied field of knowledge about to be disclosed to them; but even then, sober truth would compel us to confess that the field so pompously displayed far exceeded in extent what the best minds could hope to compass, even in fifteen or twenty years. When, however, we recollect what space of time the majority of men so addressed really can give to their education, the whole affair becomes inexpressibly ludicrous. . . . It is all very fine," he went on, "to insist that the eye cannot be understood without a knowledge of optics, nor the circulation without hydraulics, nor the bones and the muscles without mechanics; that metaphysics may have their use in leading us through the intricate functions of the nervous system, and the mysterious connexion of mind and matter. It is a truth; and it is a truth also that the whole circle of the sciences is required to comprehend a single particle of matter; but the most solemn truth of all is, *that the life of man is three-score years and ten.*" He justly observed that much disquietude was felt by students, "and especially by the best informed and best disposed," when, at the entrance of their profession, they were met by obstacles which seemed insurmountable; and he concluded that "a well-weighed scheme of professional education, sound and practicable, comprehensive and moderate in its requirements," would have the special benefit of satisfying the minds of students themselves that at each step of their progress they are in the right path. If this was true in 1836 it is more than ever true now; indeed, we find Sir Clifford Allbutt writing in 1906, "For two generations we have been loading and loading this brief curriculum as if our ambition were to teach many things ill rather than a few things well. . . . One may spend a lifetime on many acquirements and yet be uneducated."

In our previous article it was mentioned that Sir George Newman subscribed to the opinion that one way of unloading the curriculum was by teaching the preliminary sciences in the secondary schools. In some secondary schools it would, he said, be practicable to cover within two years the ground of all preliminary sciences ancillary to medicine, making it unnecessary for the student to devote any time at the medical school to their study. This was the view also of the Royal Commission on University Education in London. Any further teaching of these sciences may properly be in direct relation with anatomy, physiology, and pathology. Again, in another part of the report, it is suggested that the study of anatomy and physiology should be stripped of useless memorizing of unimportant detail; that a considerable amount of materia medica and some pharmaceutical work might be abolished, the number of systematic lectures in almost all directions diminished, and the examination system brought into subjection. The curriculum, it is suggested, can be, by these means, so simplified that the undergraduate shall be able to study his subjects more deeply. Here we come at once to the time difficulty. Sir George Newman quotes an opinion of Mr. A. Flexner that "it matters little what particular facts the student knows at graduation, for he can in any case know comparatively few, provided intensive training in a few branches has fixed a keen and sound mental disposition." Thus crudely expressed we conceive this to be a dangerous heresy; a man himself trained in medicine would not have emitted it, and when we come to Sir George Newman's own recommendations we find this clearly implied, and wonder why he quoted Flexner. The curriculum, he says, must first of all be strong in anatomy, physiology, and pathology. Next the student must be thoroughly trained in clinical examination and the interpretation of physical signs, for "no new inventions or methods, no instruments of precision, can absolve him from the duty of his own senses in this matter." This well states what has been the strong point of English medical education. It is characteristic of the system and consonant with the national temperament. Thirdly, Sir George Newman would have the student give more time and work more intelligently in the out-patient department on children's ailments and on subjective symptoms, every mode or device being used to bring the student into immediate and personal touch with the beginnings of disease. Fourthly, the student should be more fully instructed as to treatment, not only by drugs and the like, but by physical methods; and fifthly, he ought all through to have enforced on his attention the means for the prevention of disease, not merely infectious but other. Now if all this is true, as we believe it is, Mr. Flexner's dictum is seen to be inapplicable. It does matter very much what particular facts the student knows at graduation, and if he fulfils Sir George Newman's five requirements he will be liable to an indigestion of facts unless his teachers are skilled to train him to appraise the value of the facts, to point out their relation to each other, and to help him to think about them.

We are thus brought to the conclusion that the subjects, theoretical and practical, a medical graduate ought to know are too numerous and too complicated to fit into the curriculum, even when this is voluntarily extended from the minimum of five years to six. Time is to be gained at the one end by getting rid of the preliminary sciences at the secondary schools; but at the other it is to be extended by the organization of graduate teaching.

[8] Spratt's *History of the Royal Society*. 1667.

CLINICAL MEETING OF THE BRITISH MEDICAL ASSOCIATION IN APRIL.

THE programme subcommittee has now decided on the main subjects for discussion at the special scientific and clinical meeting of the British Medical Association which will be held in London in the second week of April. After the reception on Tuesday evening, April 8th, by the President of the Association, the three sections—of medicine, of surgery, and of preventive medicine and pathology—will meet on the morning of Wednesday, April 9th, and on

the two following days. Colonel C. T. C. de Crespigny, D.S.O., A.A.M.C., and Colonel C. H. S. Frankau, D.S.O., A.M.S., have been appointed organizing secretaries of the sections of medicine and surgery respectively. The secretary of the section of preventive medicine and pathology has not yet been formally appointed; it is hoped that Major Ellis, C.A.M.C., will be able to act, and in the meantime Professor S. G. Shattock, F.R.S., and Dr. J. A. Arkwright of the Lister Institute have consented to serve as acting secretaries; they had the assistance in the early stage of Lieut.-Colonel C. J. Martin, F.R.S. On Wednesday morning, April 9th, a discussion will be held by the section of medicine on war neuroses; by the section of surgery on thoracic injuries; and by the section of preventive medicine and pathology on the dysenteries—amoebic and bacillary. On Thursday morning there will be, as at present arranged, a combined meeting of the sections of medicine and of preventive medicine and pathology for the discussion of influenza and its complications, while the section of surgery will discuss shock. On Friday morning the section of medicine will discuss cardiac insufficiency and venereal disease; orthopaedic subjects will be discussed by the section of surgery, and malaria by the section of preventive medicine and pathology. A special feature of the meeting will be the afternoon demonstrations; these will cover a wide field of practical medicine and surgery. There will be demonstrations of neurological cases at the National Hospital for the Paralysed and Epileptic, Queen Square, W.C., and Dr. Mott will give a demonstration at the Maudsley Hospital on functional neuroses. The surgical demonstrations will include the methods for the treatment of shock and the selection of fracture appliances, including the application of Thomas splints for injuries of the thigh, the manufacture and adjustment of artificial limbs, and illustrations of the methods adopted at the Queen's Hospital for facial injuries, Sidcup. Opportunities will also be afforded for attending demonstrations by Professor Keith and Professor Shattock in the museum of the Royal College of Surgeons.

DEGREES FOR LONDON STUDENTS.

IT is now more than a quarter of a century since the British Medical Association, moved thereto by the late Mr. Macnamara, then President of the Metropolitan Counties Branch, published a reasoned report on the unsatisfactory nature of the relation of the medical schools in London to the University, and on the difficulty medical students encountered in obtaining a degree. In later years the subject was frequently debated and more than one proposal was made for a new university for London, either a medical university or a federal university of London colleges, leaving to the present University its functions as an imperial institution. In 1913 the Royal Commission on University Education in London stated that less than one-third of the students of the medical schools in London were undergraduates of the University of London, and that the schools could "scarcely be said to have any closer connexion with the University of London than with the Universities of Oxford and Cambridge, or with the Conjoint Board of the Royal Colleges." The recommendations of the Royal Commission have not produced any change in the position, for its three university medical colleges with complete professional staffs have not yet been established, whatever the early future may have in store. Meanwhile, discussion on the position of students of the Imperial College of Science and Technology has been revived. The disadvantage under which they lie, as compared with students in other centres, is due to the fact that as their college is not a constituent part of the University of London they cannot in the ordinary course obtain a degree in science. It is claimed on their behalf that an Imperial University of Technology should be established, and that the Imperial College should be, at least, its nucleus. The Royal Commission reported dead against the establishment of a technological university in London and advised that the Imperial College should be amalgamated with the reconstituted University of London. There are differences between the case for the students of science and technology and that for students of medicine, but the similarities are greater, and the disadvantages of the present condition of things are in some respects identical. It is unjust to both classes of students, since they suffer in after-life because they have chosen to take their special education in London where the opportunities in both instances are unrivalled. For somewhat different reasons the proposal for a University of Law in London, to be an imperial school of law, has again come under discussion in spite of the adverse opinion of the Royal Commission, which considered that the University of London should have a Faculty of Laws, and that the degrees in law should be recognized by the Inns of Court. This matter is remote from medical education, but it is an indication that thoughts are again turning to plans for the better organization of university education in London, so that students who resort to it may benefit to the full from a complete training and enjoy the academic recognition they have earned.

MEDICAL GRADUATE COURSES IN EDINBURGH.

THE universities have felt the returning flow of life into its natural channels sooner and the stream is stronger and fuller than they had dared to expect. That they will rise to so great an occasion we have already had some evidence, and we publish elsewhere a detailed statement of the arrangements made in Edinburgh, with the co-operation of the colleges, for medical courses specially designed to meet the needs of the younger graduates who were called to serve in the armed forces of the Crown immediately after graduation. The scheme aims at supplying the graduate with a means of thoroughly re-equipping himself for medical practice. He is partly to be taught and partly he is to teach himself. In the morning hours he will work in the departments of anatomy, physiology, pathology, or bacteriology, and in the wards of the hospitals; and in the afternoons he will receive instruction in the Royal Infirmary, the Royal Hospital for Sick Children, and the other hospitals included in the scheme. He will have a choice of the kind of work to which he specially wishes to devote himself. In this way the graduate clinical teaching will not interfere with that of undergraduates which (in Edinburgh) is carried on before 2 o'clock in the day. Further, in all the three courses the teachers will be arranged in teams, and the whole clinical material of all the wards will be pooled; thus all the teachers will share in giving instruction, and each subject discussed will be illustrated by a large variety of cases. If the graduate desires to take the medical as well as the surgical course he will prolong his stay for three months more; and if he wishes also to take out the vacation courses in obstetrics and gynaecology or in such special subjects as ophthalmology, dermatology, or venereal diseases, he will remain in or go to Edinburgh for the months of August and September.

MEDICAL DEPARTMENT OF THE PENSIONS MINISTRY.

IT is officially announced that the Minister of Pensions, Sir Laming Worthington Evans, who succeeded Mr. Hodge when the Ministry was reconstituted recently, has decided to effect certain changes in the administration of the medical branch. In the transfer of hospital accommodation and medical personnel for disabled men from the military authorities to the Pensions Ministry, it is essential to ensure the closest co-operation between the navy, army, and air force, and the ministry. With that end in view, the Minister has appointed Colonel A. L. A. Webb, at present Assistant Director of Medical Services, War Office, to be Director-General, subordinate to whom

there will be three Directors of Medical Service, each at the head of a definite branch of the work of the department. Sir John Collie, C.M.G., who is about to resume his position at the London County Council, from which he was temporarily released, has been invited, and has consented, to act as Consulting Medical Officer to the Ministry on resigning his appointment as Director of Medical Services. Colonel Webb, who entered the Royal Army Medical Corps in 1889, received the C.M.G. and was promoted brevet colonel for his services during the war. He has been for some time head of the hospital department in the office of the Director-General A.M.S., where his administrative work has been very highly appreciated. The task before him in the Pensions Ministry is one of great importance and no little difficulty; co-ordination of the several departments concerned with the treatment and education of the disabled man is one of the most essential needs of the country to-day.

VAGOTONIA AND SYMPATHICOTONIA.

A good deal has been written lately about vagotonia and sympathicotonia, terms introduced by Eppinger and Hess to account for and describe nervous symptoms caused by abnormal activity of the vegetative nervous system. These names are somewhat impressive and require some explanation; by vagotonia is meant increased tonicity of what Hess and Eppinger called the autonomic (parasympathetic) system, namely, the cranial, medullary, and sacral outflow of the vegetative nervous system. Professor J. N. Langley originally introduced the words "autonomic system" for what was formerly spoken of as the sympathetic, and it is unfortunate that Eppinger and Hess should restrict its use to a part only of the whole, thus causing some confusion. Sympathicotonia refers to increased tonicity of the sympathetic or the remaining part of the vegetative nervous (old sympathetic) system, and is supposed to depend on an increased continuous secretion of adrenalin into the circulation, vagotonia being regarded as the result of an excessive amount of a hypothetical substance, autonomine, the counterpart of adrenalin. Normally there is an equilibrium between the autonomic and the sympathetic systems, but when from any cause this balance is disturbed, the action of one becomes predominant and symptoms result. By means of drugs which act on the two divisions of the vegetative nervous system these disturbances become more pronounced and the diagnosis of the respective conditions is facilitated; thus, the subjects of vagotonia are sensitive to pilocarpine and physostigmine, and the manifestations thus produced are counteracted by atropine, whereas the patients with sympathicotonia are made worse by adrenalin, and although they are benefited by atropine it does not act as an antidote to the same extent as in vagotonia. Two papers bearing on the subject may now be briefly referred to. In a destructive criticism of the whole theory Swale Vincent[1] urges that as there is no proof of a continuous secretion of adrenalin into the circulation the grounds for the imaginary existence of autonomine are based on a false analogy, that Eppinger and Hess have evolved this hormone out of their inner consciousness, and that the whole conception is highly speculative and has little or no experimental or clinical evidence in its favour. Matsuo and Murakami,[2] of the medical clinic of the Kioto Imperial University of Japan, accepting with some modification Eppinger and Hess's views, investigated enteric fever in which there is sometimes an unexplained slowness of the pulse. In 46 cases of bacteriologically proved typhoid fever injected with atropine under the same conditions as Marris's cases, they found that atropine was quite effective in quickening the pulse, especially those with bradycardia. Marris, as is well known, found that atropine did not quicken the pulse in enteric fever to the same extent as in healthy persons or in patients with diseases other than enteric; and for the divergence of their results the Japanese observers cannot offer any explanation. From examination of the vegetative nervous system in 38 cases of enteric fever by means of injection of atropine, adrenalin, and pilocarpine they concluded that 14 cases corresponded to vagotonia and 11 to sympathicotonia, so that the majority of the cases showed one or other condition. In many of the cases with well marked slowing of the pulse vagotonia was present and may therefore be the cause, whereas many of the cases without a slow pulse showed sympathicotonia. The 5 fatal cases out of the 38 all showed sympathicotonia, and as this state is often accompanied by a rapid heart, which has long been recognized as a bad prognostic in typhoid, the existence of sympathicotonia may be of significance in the prognosis of the disease.

[1] Swale Vincent, review of Vagotonia, *Endocrinology*, 1917, i, 459-466.
[2] J. Matsuo and J. Murakami. *Arch. Int. Med.*, Chicago, 1918, xxi, 399-410.

THE EUGENIC MARRIAGE.

THE new Norwegian marriage law came into force on January 1st, 1919. It may not represent the unadulterated eugenic ideal, but it is so great a step towards it as to be almost revolutionary. It contains eighty-one sections, but the following are some of the salient points: A man under 20 and a woman under 18 may not marry without the consent of the authorities. Birth and baptism certificates must be produced before the banns are published. Under certain conditions, one or both of the contracting parties may be required to show that they have not been insane. Both must declare in writing that they are not suffering from epilepsy, leprosy, syphilis, or other venereal disease in an infectious form. In the other alternative the subject of any of these diseases must prove that the other party to the marriage contract is cognisant of the fact, and that both parties have been instructed by a doctor as to the dangers of the disease in question. The doctor concerned is not to be tied by professional secrecy and is bound to interfere if he knows that any one of these diseases is being concealed by either side. A written declaration must also be given by the candidates for marriage as to previous marriages and to children born to them out of wedlock. The marriage may be nullified if it is subsequently proved that insanity or any of the above diseases have been concealed, or if an incurable morbid condition, incompatible with married life, exists. Dissolution of the marriage may also be claimed if false declarations have been made or obstacles concealed. Again, if the woman has become pregnant by another man, or if the man has rendered another woman pregnant and this has not been revealed, dissolution of the marriage may be claimed, whether the child of this irregular union be born before or after the marriage; such a claim must be made within six months of the facts becoming known to the claimant. No woman may marry again till ten months after the termination of her previous marriage if she is pregnant at this period. Many other causes are defined as valid for the dissolution of marriage, and it is evident that henceforth in Norway it will often be difficult to marry in haste, and that the facilities for escaping from a hasty, ill-judged marriage will prove to be numerous and varied.

WASTED RECORDS OF DISEASE.

THE statistical study of disease is a branch of investigation now held to contain great promise of reward for medicine and surgery. Particularly is this the case with the early stages of chronic diseases, those that fill the out-patient departments of our large hospitals before the time comes when increasing disability makes their victims the often bedridden inmates of hospitals, their own homes, or various eleemosynary institutions. The importance of the early study of these chronic disorders has often been urged upon the medical profession by able and experienced

writers in prefaces, books, and periodical literature. Perusal of the latest volume of *St. Thomas's Hospital Reports*, dealing with the year 1915 and published at the end of last year, brings the subject once more before the mind. In this volume the reader finds an exhaustive and admirable statistical account of the work done in the various departments of a great hospital in a twelvemonth, together with brief but detailed accounts of cases or conditions presenting points of especial interest. In themselves, of course, however well written, such *Reports* as these do not afford enlivening reading, but, taken in the lump, they contain a great deal of buried treasure which can be unearthed only by the statistical method of comparison. Here, then, we have a great opportunity for a statistical department of a new Ministry of Health, if such a one there be. It should be the duty of a coming Government department to take advantage of so full and detailed a report of hospital work as this, and also to encourage certain others of our larger hospitals in town or country to begin or to resume the publication of similar well ordered annual reports of cases admitted to their care. For it is by the co-ordinated study of such records in the mass—a task well fitted for a governmental department—that we may hope to move a step forward in our knowledge of the first stages of many common chronic maladies, and of the means indicated to secure, if possible, their prevention rather than their cure. Without such study these cases fall into neglect for want of a due appreciation of their inherent though as yet unrealized gravity. Their importance being underestimated, they fail to obtain the continuity of skilled observation and treatment they really require. This loss of opportunity, we hold, can best be rectified by the emphasis that will be laid upon such instances when they stand forth dissected from the mass of statistical information in which they are now, for want of analysis, involved.

THE HOUSING DEPARTMENT.

THE President of the Local Government Board has appointed Sir James Carmichael, K.B.E., building contractor, of London, who has been chairman of the Munition Works Board, to be Director-General of Housing in England and Wales. The department of which he is to take charge will include central organizations for carrying out the Government policy of affording financial and technical assistance in the preparation of houses for the working classes to local authorities and other bodies, including public utility societies composed of large employers of labour who have plans for the erection of model villages near their works. Dr. Addison has undoubtedly taken this step in view of the magnitude of the work to be done and the serious financial considerations which arise. Advances are to be made to local authorities for the erection of the houses, which are to be valued after seven years. Any loss then ascertained to have been incurred is to be met as to 75 per cent. by the Treasury and as to 25 per cent. by the local rates. Objection has been taken in certain localities to this plan, on the ground that the local liability, in the event of a loss, should not exceed a rate of 1d. in the £, and it is probable that the suggestion to restrict the liability to a small extra rate will be accepted. Meanwhile 1,070 local authorities have arranged to prepare plans, and the preparations for the erection of the first instalment of 300,000 houses are said to be in a forward state. The central department has been strengthened by the appointment of various experts in building, and housing commissioners have been appointed to assist the local authorities in the preparation of schemes.

THE first session of the new Parliament was opened on Tuesday, when Mr. Lowther was elected Speaker. No other business was done; nor can any be done until the members have been sworn in, and the King's speech is delivered by him next Tuesday. Mr. Lloyd George is expected to make a statement with regard to international affairs at the earliest possible date, and among the first bills to be introduced will be one for the erection of half a million houses for the working classes, to make up for the stoppage of building during the war, and another for the settlement of ex-soldiers on the land. The pledge to put forward a Ministry of Health Bill will undoubtedly be fulfilled, but the measure, after its introduction, will almost certainly be referred to grand committee.

THE BELGIAN DOCTORS' AND PHARMACISTS' RELIEF FUND.

At the last meeting of the Executive Committee of this Fund a letter was received by the Committee from Dr. V. Pechère, the President of the Comité National de Secours et d'Alimentation (Aide et Protection aux Médecins et Pharmaciens Belges Sinistrés). The Comité National is the body sitting in Brussels to whom the dispensation of the contributions of the funds in behalf of the suffering Belgian doctors and pharmacists in Belgium has been entrusted. The Belgian Doctors' and Pharmacists' Relief Fund has raised upwards of £25,000 during its life of a little over four years. The greater part of this money has been received directly from British doctors and pharmacists at home, in the colonies, and in India, though during the closing stages of the war substantial grants have come from the American Red Cross, to the enormous benefit of the charges of the Fund. After the immediate wants of Belgian doctors and pharmacists and their families, arriving in this country as refugees, had been met by the Fund, the bulk of the money was duly distributed in monthly donations varying from £800 to £400 among Belgian doctors and pharmacists remaining in Belgium, the organization of which Dr. Pechère is the head undertaking the difficult and delicate task of distribution. Dr. Pechère's committee has wisely husbanded the contributions sent to them, so that a certain amount of money should remain in hand for the succour and rehabilitation of Belgian doctors and pharmacists after the war. In his letter Dr. Pechère made the generous suggestion that the money should be returned to the Fund, but this was not entertained by the committee. It was definitely stated in the original programme of those who organized the Fund that it would be impossible for British doctors and pharmacists to give very much money, because, when the immediate needs had been met, heavy demands for rehabilitation must remain. Many doctors and pharmacists in Belgium were materially ruined, and will not be able to return to work without pecuniary grants. All readers of the medical and pharmaceutical journals who have kept the objects of the Fund in recollection will approve of the decision of the committee of the Fund.

Dr. Pechère in his letter expressed special thanks to Sir Rickman Godlee, Chairman of the Executive Committee, to Dr. S. Squire Sprigge (Editor of the *Lancet*), Honorary Secretary of the Fund, and to its Honorary Treasurer, Dr. Des Vœux, to his Secretary, and to Miss Des Vœux.

The Belgian Doctors' and Pharmacists' Relief Fund is closed as from Monday next, February 10th, the sum of £96 16s. 6d. remaining in the hands of the Honorary Treasurer being probably sufficient to meet any remaining calls from Belgian refugees in this country. The Fund has disbursed the whole of the sum collected—namely, £25,000—save the small sum in hand; and the cost of collection and distribution has been under £200, including the postage of reports and circulars, and their printing and production at war rates. The secretarial work and that of the Treasurer has been done gratuitously, both by the officers named and by their assistants; a large proportion of the postage has been defrayed by the *Lancet*; the auditors made their inspections and reports on the books of the Fund for a nominal fee, and the bank treated the Fund with special courtesy. These are the things that account for the economical administration of the Fund's resources.

The following subscriptions have been received up to Monday, January 27th:

	£	s.	d.
Hampshire Pharmacists' Association, per Mr. C. H. Baker (making £56 5s.)	6	5	0
Dr. Charlotte H. Warner	1	0	0
Dr. Alfred Cox (monthly)	1	1	0

THE WAR.

CASUALTIES IN THE MEDICAL SERVICES.

ARMY.

Deaths.

CAPTAIN P. FERGUSON, R.A.M.C.

Captain Philip Ferguson, R.A.M.C., died of septicaemia at Horton War Hospital on January 28th, aged 34. He was the only son of Dr. Ferguson of Manchester, and was educated at the Victoria University in that city, where he graduated M.B. and Ch.B. in 1906, and at the London Hospital, also taking the diploma of F.R.C.S.Eng. in 1913. While a student he filled the posts of senior demonstrator in physiology and assistant demonstrator in anatomy at Victoria University, and afterwards those of house-surgeon at Manchester Royal Infirmary and at the Throat Hospital, Golden Square, London. He took a temporary commission as lieutenant in the R.A.M.C. on August 16th, 1914, in the second week of the war, and was promoted to captain after a year's service.

CAPTAIN R. N. PORTER, R.A.M.C.

Captain Robert Nuttall Porter, R.A.M.C., died at Ruthin, North Wales, on January 25th, aged 38. He was the eldest son of Sir Alexander Porter, ex-Lord Mayor of Manchester, and was educated at Manchester Grammar School and at Victoria University, Manchester, where he graduated M.B. and Ch.B. in 1904, also taking the diploma of F.R.C.S.Eng. in 1910. After filling the posts of house-surgeon of Manchester Royal Infirmary and of Leicester Infirmary, and of medical superintendent and surgical registrar of the Seamen's Hospital, Greenwich, he went into practice about three years ago at Derby, where he was honorary medical officer of the Derbyshire Children's Hospital. On January 1st, 1918, he took a temporary commission as lieutenant in the R.A.M.C., and was promoted to captain after a year's service. He contracted his fatal illness while serving in France.

Repatriated.

Captain C. C. Jones, R.A.M.C.
Captain G. R. Lipp, M.C., R.A.M.C. (temporary).
Captain H. S. Moore, R.A.M.C.(S.R.).
Captain C. O'Malley, M.C., R.A.M.C. (temporary).
Lieutenant F. W. M. Lamb, R.A.M.C.(S.R.).

DEATHS AMONG SONS OF MEDICAL MEN.

Davison, Rashell Montague Rashell, Captain 3rd Battalion North Staffordshire Regiment, youngest son of Dr. Rashell Davison of New Malden, Surrey, died on January 27th, of wounds received in action on March 22nd, 1918. He was wounded and taken prisoner on March 22nd last while serving with the 8th Battalion of the Leicestershire Regiment, and had recently been repatriated.

Haydon, Allan, Lieutenant Royal Engineers, youngest son of the late Dr. Ernest Haydon, died of pneumonia following influenza at the Military Hospital, Palace Green, Kensington, December 28th, 1918, aged 27. He attained his rank on July 1st, 1917.

[*We shall be indebted to relatives of those who were killed in action or died in the war for information which will enable us to make these notes as complete and accurate as possible.*]

HONOURS.

THE following awards to medical officers are announced in a Supplement to the *London Gazette* of January 31st, "for conspicuous gallantry and devotion to duty" in the field.

Bar to D.S.O.

Major (temporary Lieut.-Colonel) David Ahern, D.S.O., No. 11 Field Ambulance, R.A.M.C.

From August 30th to September 3rd, 1918, during operations on the Arras front, he was responsible for the clearing of casualties from the divisional front. He showed great forethought in selecting sites for his forward posts, especially in establishing one post in a village which proved of the utmost value as an advanced dressing station later on. He was wounded while at his work, but refused to leave until the conclusion of operations. His energy and resource were instrumental in the prompt evacuation of the wounded. (D.S.O. gazetted June 4th, 1917.)

Captain (acting Lieut.-Colonel) Alexander Donald Fraser, D.S.O., M.C., No. 9 Field Ambulance, R.A.M.C.

He was in charge of bearer divisions during the operations in the neighbourhood of Moyenneville—Ervillers—St. Leger from August 21st to August 28th, 1918, and was continually among the leading troops under heavy shell and machine-gun fire, directing the evacuation of wounded from regimental aid posts. He managed to get ambulance cars close up to the firing line, which greatly accelerated the clearing of casualties to the rear. He was untiring throughout the whole period, and set a fine example to those under him. (D.S.O. gazetted June 4th, 1917.)

Major (acting Lieut.-Colonel) Charles Reade Munroe Morris, D.S.O., 99th Field Ambulance, R.A.M.C.

For exceptional gallantry and devotion to duty on September 20th to 24th south-west of Villers Guislain, in working continually for five days under heavy shell fire, supervising and co-ordinating the work of the medical officers while at work at night in the advanced dressing station. It was twice blown in by shell burst. He carried out important surgical work, and by his pluck and endurance set a fine example to all around him. (D.S.O. gazetted June 4th, 1917.)

D.S.O.

Lieut.-Colonel William Harold Kerr Anderson, 13th Field Ambulance, C.A.M.C.

During the operations before Arras, September 2nd to 5th, he was in charge of the evacuation of wounded. He succeeded in keeping in close touch with the infantry during the whole of the battle, so that the wounded were evacuated almost as soon as they became casualties. His duties were often performed under enemy artillery fire, which caused many casualties, but by his courage and personal example he kept his men at their splendid work until all casualties were carried out.

Major (acting Lieut.-Colonel) William Alfred Gordon Bauld, No. 7 Canadian Cavalry Field Ambulance, C.A.M.C.

During mounted operations from October 8th to 11th, 1918, he was in command of the advanced cavalry field ambulances. On the night of October 9th–10th, when ordered to search and clear the wounded from three villages, which were being heavily shelled, and the approaches badly damaged by craters, he organized the evacuation of the wounded, making certain that all were found and removed. He showed great coolness and energy.

Major Donald Dunbar Coutts, A.A.M.C., attached 24th Battalion Australian I.F.

On September 1st, 1918, during the attack at Mont St. Quentin, although the regimental aid post was consistently shelled, he attended the wounded almost continuously for fifty two hours, during five of which he was forced to wear his gas respirator, displaying throughout the greatest courage and devotion to duty. On the day prior to the attack a shell burst on a dug-out, wounding several men and pressing one down, severely wounded, blocking the entrance. He immediately went forward, regardless of intense shell fire, and succeeded in extricating the man and removing him, over exposed ground, to the rear.

Major George William Hall, 12th Field Ambulance, C.A.M.C.

During the action in front of Arras, from September 2nd to 6th, he was in charge of the evacuation of wounded. Time and time again he went through heavy enemy shell and machine-gun fire to direct the clearing of the wounded. On the afternoon of September 2nd he succeeded in clearing a number of wounded who were being shelled with gas shell to a place of safety, and dressed many wounded under heavy fire. His work throughout the battle was admirable.

Temporary Captain (acting Major) Hugh Ross Macintyre, M.C., R.A.M.C., attached 69th Field Ambulance (Italy).

During operations on the Piave between October 27th and 29th, 1918, especially on the morning of the 27th when in charge of stretcher-bearers, he crossed to the right bank of the Piave immediately behind the infantry under very heavy fire, and supervised the collection and evacuation of the wounded under great difficulties, having to ford the river several times. He set a very fine example to all under him by his untiring energy and total disregard for his own safety.

Lieut.-Colonel James Hardie Neil, No. 3 Field Ambulance, N.Z.A.M.C.

During operations near Bapaume and Bancourt from August 23rd to September 3rd, 1918, he was in command of the ambulance, and constantly visited the forward regimental aid post under heavy shell fire, and selected positions for the bearer relay posts. During the action round Bancourt he went forward with two light ambulance cars to within a few hundred yards of the front line and supervised the evacuation. It was owing to his gallantry and personal supervision that the evacuation of the wounded was so successfully carried out.

Temporary Captain (acting Major) Philip Randal Woodhouse, M.C., 9th Field Ambulance, R.A.M.C.

On September 27th, 1918, at Maison Rouge, when loading wounded on an ambulance wagon, it was damaged, and an ammunition dump close by set on fire by heavy shelling. He at once got the fire out and evacuated the wounded to safety. On two other occasions he did good work under heavy shell fire, clearing a road which was blocked by a tree blown across it, and also in evacuating wounded when his advanced dressing station was hit by a shell.

Third Bar to Military Cross.

Temporary Captain Charles Gordon Timms, M.C., R.A.M.C., attached 7th Battalion, Royal Fusiliers.

During a severe enemy barrage near Cambrai on October 1st, 1918, when his commanding officer was wounded, he at once took up a squad of stretcher-bearers into the barrage to the rescue, tending his wounds and seeing that he was conveyed to a place of safety. (M.C. gazetted July 18th, 1917. First bar gazetted July 26th, 1918. Second bar gazetted January 11th, 1919.)

Second Bar to Military Cross.

Temporary Captain (acting Major) George Boyd McTavish, M.C., 99th Field Ambulance, R.A.M.C.

When west of Villers Guislain, from September 19th to 27th, 1918, he worked for eight days and nights, refusing to be relieved, walking constantly through heavy barrages and machine-gun fire, organizing bearer squads on the whole divisional front. Although gassed, he still carried on, and saved the life of an officer who was knocked over by a shell when he was talking to him, holding an artery until help came, he himself having been knocked over by the same shell. (M.C. gazetted October 29th, 1916. Bar gazetted September 16th, 1918.)

Bar to Military Cross.

Captain John Ernest Affleck, M.C., No. 9 Field Ambulance, C.A.M.C.

During the fighting east of Arras, August 26th to 28th, 1918, his work was carried out under continuous shell and machine-gun fire, and many times he led his bearers close up to the front line, collecting seriously wounded men. By his cool judgement and energy he was enabled to get all the wounded under cover. (M.C. gazetted September 17th, 1917.)

Temporary Captain (acting Major) John Crawford, M.C., 136th Field Ambulance, R.A.M.C.

In the area north of Ypres occupied by Belgian troops on September 28th to 30th, 1918, he was conspicuous for his indefatigable efforts in evacuating the wounded from six field batteries and ten trench mortar batteries. During the advance he was constantly well ahead, with complete disregard for his own safety, under heavy shell fire, and by his initiative and organization all the wounded were evacuated smoothly and rapidly. (M.C. gazetted March 3rd, 1917.)

Captain William Donald, M.C., R.A.M.C.(S.R.). (Salonica.)

During operations against Sugar Loaf and Thetassel on September 18th and 19th, 1918, he went fearlessly forward under the heaviest fire to rescue wounded lying in front of the enemy's positions. By his courage he set the finest example to his stretcher-bearers and was instrumental in saving many lives. He worked unceasingly for three days, and refused to rest until all wounded had been brought in. (M.C. gazetted January 1st, 1918.)

Captain Charles Marsh Gozney, M.C., 5th (London) Field Ambulance, R.A.M.C.

During the attacks on Happy Valley and Moislains between August 24th and September 2nd, 1918, he showed great initiative in moving his aid posts forward and keeping in touch with the advanced troops. His arrangements for the evacuation of the wounded were splendid, and he undoubtedly was responsible for the saving of many lives. (M.C. gazetted August 16th, 1917.)

Temporary Captain Francis Henderson, M.C., No. 8 Field Ambulance, R.A.M.C.

At Masnieres on October 1st, 1918, he worked under heavy fire throughout the day and cleared the battlefield all through the night. Hearing that two officers of another division were lying out severely wounded, he made his way to them under heavy shell fire, dressed them, and brought them safely in. His work throughout was magnificent. (M.C. gazetted July 26th, 1918.)

Captain Kenneth Arthur McLean, M.C., A.A.M.C., attached 7th Brigade Australian Field Artillery.

On August 31st, 1918, near Clery, the battery was heavily shelled, two men being killed and two badly injured. He immediately went to the battery and commenced dressing one man who could not be moved. He continued his work until one shell burst close to him, wounding him severely in the arm, and mortally wounding the stretcher-bearer who was assisting him. He showed marked courage and devotion to duty. (M.C. gazetted July 26th, 1918.)

Temporary Captain Henry Leslie Messenger, M.C., R.A.M.C. (Salonica.)

On September 18th, 1918, near Doldejeli, he led a party of stretcher-bearers some 400 yards across the open through a heavy barrage, and succeeded in rescuing and bringing in a large number of casualties to his advanced post. The next day he established touch forward with the attacking battalions under heavy artillery and machine-gun fire. Throughout the action he showed the greatest energy and disregard of personal danger. (M.C. gazetted October 15th, 1918.)

Captain Duncan Arnold Morrison, M.C., No. 1 Field, C.A.M.C.

During the operations on September 2nd and 3rd, 1918, between Cagnicourt and Buissy, he kept in touch with four infantry battalions, repeatedly going up and down under heavy fire, hastening the evacuation of the wounded. He was untiring in searching for any who might have been overlooked and directing the bearers in their duties. His coolness and judgement helped on the evacuation enormously. (M.C. gazetted January 11th, 1919.)

Captain (acting Major) William Barry Postlethwaite, M.C., R.A.M.C. (S.R.), attached No. 54 Field Ambulance.

On August 22nd, 1918, he cleared casualties at the crossing of the Ancre river. On August 25th, 1918, he had great difficulties in the advance beyond Fricourt, owing to heavy shelling, but by a daring reconnaissance found a comparatively safe track for evacuating the wounded. On August 30th, north of Combles, after searching all night, he again found a practicable evacuation route. His endurance and initiative were beyond praise. (M.C. gazetted October 18th, 1917.)

Captain (acting Major) John Gray Ronaldson, M.C., R.A.M.C. (S.R.), attached No. 14 Field Ambulance.

During the operations near Cambrai from September 18th to 30th, 1918, he was in charge of the bearers clearing the divisional front, and during the whole period he was living under heavy shell fire, including gas. Through casualties to medical officers, he had only one officer left to help him, but by constantly visiting the front posts he cleared all casualties, and his cheerfulness kept up the spirits of the bearers. (M.C. gazetted January 18th, 1918.)

Temporary Captain (acting Major) William Russell, M.C., 109th Field Ambulance, R.A.M.C.

Whilst in command of bearers near Bailleul on August 22nd and 24th and September 3rd, 1918, he constantly visited all the regimental aid posts by day and night, often under considerable shell and machine-gun fire, and disposed his bearers and ambulance cars with such skill that all wounded were collected and placed in the most favourable conditions for recovery with the utmost celerity. Later, he was gassed by a direct hit on his advanced dressing station, but continued to evacuate wounded until his relief arrived. (M.C. gazetted October 18th, 1917.)

Captain Cedric Murray Samson, M.C., 9th Field Ambulance, Australian A.M.C.

On the morning of August 22nd, 1918, north of Chipilly, on the Bray-Corbie Road, he took a car along to the regimental aid post in spite of heavy shelling and gas. He superintended the line of evacuation, continually taking fresh squads up to the regimental aid post through heavy fire. Again, on August 31st, he dressed a wounded medical officer and his orderly in the open, being wounded while doing so. During the period August 20th–31st, 1918, his fearless energy and devotion to duty were responsible for the rapid evacuation of so many wounded. (M.C. gazetted June 3rd, 1918.)

Captain Hugh Kingsley Ward, M.C., R.A.M.C.(S.R.), attached 2nd Battalion K.R.R.C.

On July 10th, 1918, after an intense bombardment of several hours, the enemy attacked the battalion sector east of Neuport Bains; during the bombardment he went up to the front line and remained in attendance on a badly wounded officer until he died. He was subsequently wounded while attending another officer, but continued looking after many other wounded men until he returned to the dressing station, when he worked for over two hours in the open, and when the enemy approached he stood outside to prevent them bombing the wounded. (M.C. gazetted October 20th, 1916.)

(To be continued.)

FOREIGN DECORATIONS.

The following decorations and medals have been awarded to medical officers by the President of the French Republic for distinguished services rendered during the course of the war:

Légion d'Honneur—Croix de Chevalier.

Temporary Captain (acting Lieut.-Colonel) **James Robertson Campbell Greenlees, D.S.O., R.A.M.C.**

Médailles des Epidémies (en Vermeil).

Major (temporary Lieut.-Colonel) **John Frank Cromble, D.S.O., R.A.M.C.**

Majors (acting Lieut.-Colonels): **Ralph Bignell Ainsworth, D.S.O., R.A.M.C., Edward Michael O'Neill, D.S.O., R.A.M.C.**

Captain (acting Major) **Frank Herbert Cheney Watson, R.A.M.C.(T.F.).**

Captains: **Francis Henry Guppy, R.A.M.C.(S.R.), William Thomas Wood, R.A.M.C.(T.F.).**

Temporary Captain **Robert McCheyne Paterson, R.A.M.C.**

Médailles des Epidémies (en Argent).

Majors: **Alan Worsley Holmes A'Court, A.A.M.C., Clement Lorne Chapman, D.S.O., A.A.M.C., Harold Orr, C.A.M.C.**

Captain (acting Lieut.-Colonel) **Henry Neville Burroughes, R.A.M.C.(T.F.).**

Captains (acting Majors): **Sydney James Clegg, R.A.M.C. (T.F.), Alfred Morgan Hughes, R.A.M.C.(T.F.), John Hawkes Pendered, M.C., R.A.M.C.**

Captains: **Alfred George Hebblethwaite, D.S.O., R.A.M.C. (T.F.), William Hugh Hill, R.A.M.C.(T.F.), James McLean Macfarlane, M.C., R.A.M.C.(T.F.), Thomas Jenkins Murray, R.A.M.C.(T.F.), Eric Stuart Taylor, R.A.M.C.(T.F.).**

Temporary Captains: **Ranald Montague Handfield-Jones, M.C., R.A.M.C., Lancelot Raoul Lempriere, R.A.M.C., Octavius de Burgh Marsh, R.A.M.C., Arthur Francis Savory Sladden, R.A.M.C., Alfred Edward Stevens, R.A.M.C.**

MENTIONED IN DISPATCHES.

A special Supplement to the *London Gazette*, dated January 30th, contains a list of names submitted by Lieut.-General Sir G. F. Milne, Commander-in-Chief British Salonica Force, "for gallant conduct and distinguished services rendered during the period from March 1st to October 1st, 1918." The list includes sixty-three medical officers of the A.M.S. and R.A.M.C. (Regular, Special Reserve, and Territorial) and ninety-four warrant and non-commissioned officers and men of the R.A.M.C.

A Supplement to the *London Gazette* of January 31st contains a list of names mentioned by Lieut.-General Sir J. L. Van Deventer, Commanding-in-Chief, East African Force, for excellent services rendered during the period December 1st, 1917, to July 31st, 1918. The list includes 13 officers of the A.M.S. and R.A.M.C., including one Special Reserve, 11 warrant and non-commissioned officers and privates of the R.A.M.C., 10 officers and 4 non-commissioned officers and privates of the South African Medical Corps, 4 officers of the I.M.S., 4 members of the Indian Medical Department, 3 officers and 3 warrant and non-commissioned officers of the East African Medical Service, 6 members of the Nyasaland Medical Service, 3 members of the Rhodesia Medical Corps, and 21 members of the nursing services.

The Meritorious Service Medal has been conferred upon twenty-six warrant and non-commissioned officers and men of the R.A.M.C. in recognition of valuable services rendered with the British Forces in Salonica.

The Military Medal has been conferred upon Nursing Sisters Helen E. Hansen and Beatrice McNair of the C.A.M.C. for distinguished services during an enemy air raid at Etaples on May 19th-20th, 1918.

A NEW medical periodical, with a title signifying "medical observation," has recently appeared at Athens. It is written in Greek, and is intended to counteract German influence which had become preponderant in Hellenic universities. A large part in the foundation of the new journal has been taken by Dr. Portmann, a naval surgeon attached to the French legation at Athens. Communications should be addressed to the editorial secretary, M. Sotiriades, Kalkoondi Street, 25, Athens.

Scotland.

Edinburgh Post-graduate Courses in Medicine.

The declaration of war in August, 1914, put an end for the time being to the Edinburgh post-graduate courses in medicine which had been going on since 1906 in connexion with the University and Royal Colleges. The two July courses on obstetrics and gynaecology and on diseases and defects of children had been held and the August course on internal medicine had been just begun, but the latter was suspended, and the September general course, the surgical course, and the special course on surgical diseases of the genito-urinary tract were abandoned, the energies of most of the teachers being directed to war work of various kinds. On November 13th, 1918, a meeting was held of the lecturers who had taken part in the 1914 and preceding courses of instruction. In the absence of the chairman of executive (Professor Harvey Littlejohn) the vice-chairman (Dr. Ballantyne) presided. It was decided to re-establish the post-graduate courses, but to adopt an entirely different arrangement in order to meet the needs of the younger graduates who had given themselves to war service immediately after graduation, and to make the teaching continuous all the year. The following were added to the Executive Committee: Dr. Haig Ferguson, Dr. Stewart Fowler, Dr. H. M. Traquair, and Mr. Alexander Miles, F.R.C.S.Edin. Professor Lorrain Smith took Professor Robinson's place among the university's representatives. Mr. Miles has since agreed to act as interim honorary secretary. The Executive Committee has arranged the following courses of post-graduate instruction: A, In clinical medicine; B, in clinical surgery; C, in obstetrics and gynaecology.

These are specially designed to meet the requirements of graduates returned from active service on demobilization, and are open to women graduates.

Courses A and B will be conducted during each of the academic terms:

Summer (April to June) commencing April 15th, 1919.
Autumn (October to December) commencing October 7th, 1919.
Winter (January to March) commencing January 6th, 1920.

Course C will be conducted during the vacation months, August and September, commencing August 4th, 1919.
Only one course can be taken at a time.

Course A.—*Clinical Medicine.*

This course includes lecture-demonstrations, and ward work in general medicine, medical diseases of children, tuberculosis, medical ophthalmology, neurology, dermatology, infectious diseases, mental diseases.

Members of the course shall act as temporary assistant-demonstrators in the practical classes of anatomy, physiology, pathology, or bacteriology, and as chemical assistants in the medical wards of the Royal Infirmary, the Royal Hospital for Sick Children, the Royal Victoria Dispensary for Tuberculosis, the Eye Department or the Skin Department of the Royal Infirmary.

Members will be given the option of selecting the departments in which they desire to act as demonstrators and clinical assistants, and will be allocated to these in order of application up to the number of vacancies.

Course B.—*Clinical Surgery.*

This course includes lecture-demonstrations and ward work in general surgery, surgical diseases of children, aural, nasal, and laryngeal surgery, and venereal diseases.

Members of the course shall act as temporary assistant demonstrators in the practical classes of anatomy, physiology, pathology, or bacteriology, and as clinical assistants in the surgical wards of the Royal Infirmary, the Royal Hospital for Sick Children, the ear, nose, and throat department, Royal Infirmary, or in the lock department.

Members will be given the option of selecting the departments in which they desire to act as demonstrators and clinical assistants, and will be allocated to these in order of application up the number of vacancies.

Course C.—*Obstetrics, Gynaecology, and Child Welfare.*

This course includes clinics at the Royal Infirmary on diagnosis and treatment in gynaecology, and at the Royal Maternity Hospital on the diseases of pregnancy (in the pre-maternity ward), on labours, the puerperium, and the newborn infant; lecture-demonstrations on the morbid anatomy of gynaecology, of obstetrics (including the pathology of pregnancy and the new-born), and of antenatal diseases (including teratology; demonstrations of operative measures and of instrumental appliances in gynaecology and obstetrics; and clinical instruction in mother and child welfare at the various health centres (including clerking at the antenatal clinic and at infant centres), study of the details of the working of the town system of mother and child welfare in its social and medical aspects.

Special Courses.

Courses on ophthalmology, aural, nasal, and laryngeal surgery, dermatology, venereal diseases, radiology, are being arranged.

Edinburgh Royal Maternity Hospital.

The directors of the Edinburgh Royal Maternity Hospital have recently purchased two flats in a block of buildings situated behind the hospital, in order to provide accommodation for a new department in connexion with the treatment of the venereal diseases as they affect pregnant, parturient, and puerperal patients and new-born infants. This department, we understand, is to be established as a part of the Edinburgh town scheme for the diagnosis and treatment of these maladies in the city and neighbouring districts.

Pediatrics in Glasgow.

We had the pleasure of announcing a few weeks ago that three chairs had been founded by the two Mr. Gardiners, shipowners in Glasgow, and endowed with the sum of £20,000 each. We now learn that two lectureships in pediatrics have been founded by gifts of £5,000, the one by Mr. Leonard Gow, shipowner in Glasgow, and the other by Mr. Robert Francis Barclay. The Leonard Gow lectureship, on "the medical diseases of infancy and childhood," is founded in memory of the donor's father; the Barclay lectureship, on "surgery and orthopaedics in relation to infancy and childhood," is founded in memory of the donor's seven pleasant years at the university, and his twenty years of work as honorary secretary of the Royal Hospital for Sick Children, Glasgow.

Correspondence.

THE PREVENTION OF VENEREAL DISEASE.

Sir,—I have followed with great interest the controversy in your pages on the prevention of venereal disease. It was stated by Mr. Turner (January 4th) that the fear of disease acted as a deterrent to such an extent that the feeling of security induced by a course of instruction in the use of prophylactic outfits will so increase the number of those who indulge in promiscuous sexual intercourse that the actual number of cases of acute disease will be increased. That is not the experience of the navy. Prophylactic and early preventive treatment was in existence in it before 1912, and the result has been a considerable fall in the incidence of acute disease. I have not the official figures, but the proportion of cases is certainly less than 50 per cent. of that ten years ago. In the ship of which I am medical officer, out of 130 men there has only been one case of acute disease in eighteen months, and in that case no preventive measures were used. That many have indulged, I know, because some have told me so, and others have reported to the sick bay for treatment after a night ashore. I wonder if any ship in pre-prophylactic days could show such a record, whether on home or foreign service. On the other hand, in ships where prophylactic outfits were temporarily unobtainable, the incidence has risen to 10 or more per cent. in spite of lectures on the danger of venereal disease.

If, as Dr. Browdy asserts (and I believe he is right), 80 per cent. of the population have had gonorrhoea at some period of life, how can the use of preventive measures increase this proportion? Even if those who run the risk of infection were to rise to 100 per cent., I do not see that 80 per cent. of these are liable to become infected, provided that the prophylactic outfits had clear printed instructions enclosed. Personally, I should like to see automatic machines containing these outfits placed in every public urinal in the kingdom. Their use does not require the verbal instructions of a reputable physician, as Mr. Turner suggests, but only a clearly worded paper with instructions in each box and the use of a grain of common sense by the user. By all means educate the public on the subject; but talk alone will not prevent a large percentage of men and women from indulging their sexual cravings in spite of the risk, especially when their brains are clouded by the fumes of alcohol. The knowledge that murder is punishable by hanging does not prevent murders being committed by

persons under the influence of alcohol, rage, or avarice. Will a knowledge of the dangers of venereal disease convert England into a land of ascetics?

The article of Colonel Adami, "The Policy of the Ostrich," faces courageously the facts with which we are confronted, and it is a reproach to the United Kingdom that "the Dominions are working together," while our civil and military authorities are still burying their heads in the sand. I disagree, however, with the policy of penalizing victims of venereal disease by stopping any portion of their pay—at any rate unless they neglected available precautions—because such a policy tends to encourage concealment. Stoppage of pay for this reason was abolished by the navy some time ago.

For the sake of the nation's health and for the generations to come, let us put aside our Grundian prejudices and leave no stone unturned to wipe out the evil of venereal disease by educative, legislative, chemical, and any other measures. But let us not think that the fear of infection will deter the whole of our manhood from indulging in a natural if deplorable habit.—I am, etc.,

January 30th. TEMPORARY SURGEON R.N.

RISKS AND REWARDS.

SIR,—With reference to the letter of the "Undecorated Regular" medical officer in the BRITISH MEDICAL JOURNAL of January 25th, we do not understand how this officer arrives at such definite conclusions as those expressed in his letter. We see no reason why statistics which definitely show the higher honours being allotted to regular medical officers, in preference to auxiliary medical officers, should not be published in what is the most widely read medical journal, unless the regular R.A.M.C. fear publication of such statistics to the profession as a whole.

We do not agree with your "Undecorated Regular" correspondent when he states that military medical work is "cut and dried," but would venture to suggest, on the other hand, that, during active service, and especially in forward areas, it is anything but "cut and dried," but calls for initiative, foresight, endurance, and fixity of purpose of a high standard. The statistics shown in your JOURNAL give the regular officers as possessing far and away the larger number of D.S.O.'s in comparison to those given to auxiliary medical officers, although they number many more than regular medical officers.

Bearing in mind that the D.S.O. was given until quite recently as an immediate reward for gallantry as well as for continuous good service in the field, it seems strange that the regular officer, who has been seldom seen, for at least three years, anywhere near the forward area, should receive the greater number of D.S.O.'s. We would also point out that the great majority of units that work in the forward area are commanded and staffed by auxiliary medical officers, who have borne the brunt of the medical services in this war, and have gained for the R.A.M.C. the high reputation which it now enjoys.

With regard to experience, it should be pointed out that as far as field ambulances and casualty clearing stations are concerned (units in which the Territorial officers had been carefully and efficiently trained before the war), the regular R.A.M.C. officers had little practical experience owing to the non-existence of such units under peace-time serving conditions.—We are, etc.,

B.E.F., Jan. 26th. FOUR FIELD AMBULANCE OFFICERS.

GRATUITIES OF TERRITORIAL MEDICAL OFFICERS.

SIR,—The suggestion of "T.F. Reservist," in your issue of January 25th, that gratuities on acting rank should be issued to all officers who had held such acting rank for six months *and still held it on demobilization or on November 11th, 1918*, would be as unfair as the existing army order.

Why should a man who held acting rank for over six months (in my own case for over eighteen months) be penalized just because he had the misfortune to be wounded a few months before the armistice?

I would suggest that gratuities on acting rank should be issued to all officers who held acting rank in proportion to the length of time the rank was held.—I am, etc.,

January 23th. HONORARY MAJOR, S.R.

MEDICAL RESETTLEMENT.

SIR,—The letter of Dr. H. M. Stewart, Honorary Secretary of the Sydenham District Medical Society, in the BRITISH MEDICAL JOURNAL of January 18th is interesting. It is quite true that the question of equitable treatment of the doctors who have had to leave their practice in order to join the forces must have furnished much food for thought to those who stayed at home, and also that no general action has been taken.

I speak as the sole doctor of about three dozen who was forced to leave my town, mobilized on August 5th, 1914. I left, absolutely unprovided for, a single-handed practice worth about £1,200 a year, built up in the few preceding years by my sole efforts. It is inconceivable that such a practice should, "like the baseless fabric of a vision," fade away; and yet, in spite of repeated applications on my part to my *confrères* who have stayed at home, I have only received, up to the time of writing, less than £3 from two of them for private patients treated by them for me during my absence on military service. I am grateful that the panel fees are handled by a county committee. I have proven instances in which a *confrère* received fees from my patients (who since consulted me), but ignored my request that he should hand a share to me.

In addition to this, four desirable appointments have become vacant during the past year alone; two of them are permanently filled, one is semi-permanently filled under the Local Government Board scheme for treating venereal diseases, and one is still under consideration, but in no instance has a doctor been appointed who has done military service.

These are some of my own local conditions. Naturally, during four years of military service, I have heard of many others similar, and the impression they have produced *is* about to make itself felt in the shape of very strong general action, but on the part of those chiefly wronged.

The apparent intention of the resolution recorded by the Sydenham District Medical Society is commendable, but I fail to see who is to decide which particular patients "would presumably have gone to an absent colleague." Presumption will, I am afraid, lead to grave differences of opinion where money is concerned.—I am, etc.,

January 20th. TIME BIDER.

THE FUTURE OF THE MEDICAL PROFESSION.

SIR,—Medical officers on foreign service have been deeply concerned with the trend of recent events in England as to what is going to happen to the profession in the near future. I have talked over the subject with many of my brother officers, and we are unanimously of the opinion that no radical changes should be instigated either by the Government or the various medical committees in England until either (*a*) those doctors who joined the R.A.M.C. since the outbreak of war are demobilized, or (*b*) every qualified medical man has been consulted (the machinery for doing this could easily be arranged) on that important question as to whether or not there is to be an all-round State medical service in England.

I can assure you, Sir, that the feeling is very strong on the subject, and I hope the BRITISH MEDICAL JOURNAL will, as hitherto, use its utmost endeavours to obtain equitable treatment for the profession as a whole.—I am, etc.,

B.E.F. ACTING MAJOR R.A.M.C.(T.F.).

STATE MEDICAL AID CENTRES AND MEDICAL PRACTICE.

SIR,—The profession cannot already have forgotten the fight it had over the National Insurance Act of 1911, neither can it fail to remember the struggle that centred round the so-called Harmsworth Amendment, subsection 4 of section 15 of the principal Act—the section that guards the profession from being sweated by medical aid societies. We all knew in those days how strong was the feeling against this form of medical work, and that in no circumstances would it ever have obtained our help or recognition. But while the profession has guarded itself against medical aid societies being introduced through the Insurance Act, a march, it seems, has been stolen upon us to have this form of practice introduced in another way.

While the profession has been trustfully waiting developments in the way of arranging for medical attendance on dependants, the Local Government Board has set about the doing of it, and on July 30th, 1914, they issued a memorandum, recommending all local authorities to establish maternity and child welfare schemes. This has been followed by another memorandum of August 27th, 1917, strongly insisting on this policy, and formulating details of the scheme. In those details lies the threat to the freedom, status, and emoluments of the profession. Under the national insurance scheme free choice of doctor was the rock on which we stood, but in this maternity and child welfare scheme, Clause VI of the Local Government Board memorandum reads:

> Medical attendance should be provided at the maternity and child welfare centre, and it should be regular and uniform—that is, the same doctor should attend at stated intervals. The Board do not approve of a rota of doctors, as ordinarily understood at a centre. Subject to this, the doctor may be the medical officer of health, or assistant medical officer, or a local practitioner.

Now from this it is plain that the centre is to be controlled by a single medical officer, attached to the centre. Indeed, the very nature of the method forbids a rota.

What work is embraced by the centre? The plan of procedure of the Local Government Board is that there should be a health visitor for every 400 births in any community, and it becomes the duty of the health visitor to visit each child as its birth is notified under the Notification of Births Act. This is the basis of the work, and it is a complete one. But the centre takes on other work, and the most approved plan is to appoint a health visitor for every 5,000 people, who undertakes the supervision of all children up to five years of age; she does the district work, follows up the recommendations of the school medical officer, and sees that the instructions of the tuberculosis officer are being attended to, besides arranging for maternity and pre-maternity cases. If she finds a child or mother requiring medical attention, her duty will be to report to the centre, and the medical officer of the centre then becomes responsible. The medical officer might at first ask the family doctor to carry out the necessary treatment, but for how long will people continue to pay private fees for work they have the right to obtain free of charge at the centre? It seems abundantly clear that the general medical practitioner is not intended to have any footing in maternity and child welfare centres. How will this affect the general practitioner? If the medical attention on children up to five years is taken from his charge; if he loses maternity and pre-maternity cases; if he further loses domiciliary attendance on tuberculosis and ceases to have any position with reference to school children between the ages of 5 and 15, what is there left for him to do?

Many of the changes indicated have the elements of good, but should they be carried out without the real sanction of the profession? And, further, must they be carried out to the profession's detriment? It will be strange indeed if medical aid societies, which the profession abhorred and determinedly fought against in 1911, are to be accepted and adopted in 1919 because they are State-aided and State-supported.

The profession has the right to ask, What is the British Medical Association doing in this matter? Well, the Annual Representative Meeting in 1915 issued a very nicely mannered statement and exposition of the grave dangers to the general medical practitioners if maternity and child welfare centres were established; and they further, in a mild way, suggested attendance by rota—to be told in August, 1917, by the Local Government Board that attendance by rota will not be permitted; and there the matter rests, except in this, that while the British Medical Association continues doing nothing the Local Government Board is pushing rapidly ahead and establishing centres.

May we trust the profession will recognize the occasion and take the situation in hand, and that while it advances the public good it will see to it that it preserves its traditions, its status, and its emoluments, and that it does not become sweated and exploited by State-aided and State-maintained medical institutions?—I am, etc.,

Cowdenbeath, Jan. 30th. WM. CRAIG, M.D., M.O.H.

THE REFORM OF MEDICAL EDUCATION.

SIR,—The article in the JOURNAL of January 25th, p. 107, on the reform of medical education contains much interesting matter for all readers. I particularly agree with the clause in which it supports the idea of the secondary schools being encouraged, and, if necessary, being enabled by grants to assist pupils who are destined for medicine and other kindred professional careers, by enabling them to commence their studies in the school. Secondary schools should teach such subjects as chemistry, biology, nature study, botany, physics, electricity, and mechanics, as well as they can be taught to the undergraduates or the students of a university institution. And these subjects under such circumstances might and should be acceptable at matriculation in a university. It ought to be possible for a parent to notify to the head master of a secondary school that his child is to be a doctor, a lawyer, an engineer, or to enter the Church, or into commercial life; and the last few years of his stay in the school could be devoted to such preparation for these careers as to make it possible for him to pass the necessary examination from the school directly into the university, and thereby save the expense, and, what is more important, the time expended in such studies and examinations, during university life, either internal or external. Every father of a family would welcome such a change and such a scheme. Moreover, there should be a unification of examination schemes. It is possible for any student at most universities to get credit at examinations in those subjects in which they have passed. But the University of London and the Royal University of Ireland, which is, like the former, an examining body only, require in most of their examinations that every student shall take up all subjects at each examination. The result is, that one who has failed in one subject before may fail in another afterwards owing to an exceptionally stiff paper. Thus, the college life and expenses of the student are needlessly prolonged.—I am, etc.,

Enfield, Jan. 20th. FRED. TRESILIAN, M.D., F.R.C.P.Ed.

MEDICAL UNITY.

SIR,—Many of the members of the medical profession who attended the meeting at Wigmore Hall on February 2nd must feel that the words of a prominent civil servant present at the meeting only too aptly describe the impression left on our minds of far-reaching discord: "It is pitiable." If the scene witnessed at the close of the meeting, the demonstration which led to its adjournment, is typical of trade union methods, then may our profession be long saved from trade unionism.

This demonstration of complete lack of harmony and union, when an attempt is made to set up a representative committee of medical men to discuss medical matters with the Government, convinces me more than ever before of the unwisdom of destroying or even weakening the organization we already have—an organization which, whatever its faults, has done so much for the welfare of the medical profession. I refer to the British Medical Association. This is a democratic body, and can elect whatsoever leaders it wishes. If the present leaders are not to its liking the fault lies in the apathy of the individual members, although I am prepared to admit that it is by no means easy for medical men to take an active interest in the meetings of their Divisions, and feel that there is urgent need for the elaboration of some scheme whereby the opinions of those practising in rural districts might be more certainly ascertained.

But is not the cause of such discord as showed itself at Wigmore Hall mainly due to the fact that most of us are unaware of any active policy now before the profession on which we could unite? It is too much to ask us to be united for or against a hypothetical policy of the Government. Is it not time that we drew up a plan of our own after due consideration of the various schemes that have at one time or another been propounded—part-time medical service, a state service, or the scheme outlined by Sir Bertrand Dawson in his Cavendish lecture? We should know best what changes in our present system are required, what form of service would most develop our capacity for service for the good of the community; and I firmly believe that if we can show that we are working whole-heartedly for the good of the community the public will not behave ungenerously to us.—I am, etc.,

London, W., Feb. 3rd. HAROLD H. SANGUINETTI.

The Services.

STATION HOSPITALS FOR INDIAN TROOPS.

THE following Army Instruction (India), dated November 19th, 1918, has been issued by the Government of India (Army Department):

1343. INTRODUCTION OF STATION HOSPITALS FOR INDIAN TROOPS AND FOLLOWERS.

It has been decided that, with effect from the 1st December, 1918, station hospitals for Indian troops and followers will be established in place of existing regimental and followers' hospitals.

2. Station hospitals for British troops will thereafter be known as "British station hospitals" and those for Indian troops and followers as "Indian station hospitals."

3. The system of command and administration in Indian station hospitals will be similar to that in hospitals for British troops.

4. All existing hospital arrangements for Indian troops and for regimental and departmental followers will be brought under one administrative control which will be exercised by the officer commanding the Indian station hospital. Officers of the Indian Medical Service, sub-assistant surgeons and subordinate hospital establishments will no longer be attached to Indian regimental units, but will form part of the establishment of Indian station hospitals.

5. Hospitals will be classified according to the total strength of Indian troops and followers forming the garrison as follows:

1st class Indian station hospital, where the strength of garrison (as above) is 3,000 and over.
2nd class Indian station hospital, where the strength of garrison (as above) is 2,000 and over.
3rd class Indian station hospital, where the strength of garrison (as above) is 1,000 and over.
4th class Indian station hospital, where the strength of garrison (as above) is 500 and over.
5th class Indian station hospital, where the strength of garrison (as above) is under 500.

The present classification of Indian station hospitals, which is only temporary, is shown in appendix "A" to this instruction. The permanent classification of hospitals will be carried out on the restoration of normal conditions.

6. Where more than one regimental, or combined hospital, already exists in a station, the local authorities will decide, and report to the Director of Medical Services in India for the information of the Government of India, which will be the Indian station hospital. The remaining outlying hospitals, which it is necessary to retain, will be designated and administered as section hospitals of the station hospital. The officer commanding station hospital will be in command of, and administer, all such section hospitals. Section hospitals will be supplied with equipment, medical stores and stationery from the station hospital.

7. For the period of the war, and until further instructions are issued, the Director, Medical Services in India, will appoint officers to command all first class Indian station hospitals and the hospitals at the following stations: Bakloh, Dharmsala, Almora, Shillong, Maymyo, Mandalay. Commanding officers of other hospitals will be appointed by the General Officer Commanding, Command or Independent Division, who will also appoint officers as second in command of all 1st and 2nd class station hospitals.

8. The rules governing the pay and allowances of officers of the Indian Medical Service are laid down in appendix "B" to this instruction.

9. Deputy and Assistant Directors, Medical Services, Divisions and Independent Brigades, will appoint sub-assistant surgeons to the subcharge of all Indian station hospitals.

Revised rates of subcharge allowances for sub-assistant surgeons will be announced hereafter.

10. Ward orderlies will be attached to regimental units for purposes of pay, clothing and rations, as at present. Details as regards the appointment, pay, and promotion of ward orderlies are given in appendix "C" to this instruction.

11. Orders will be issued shortly regarding the formation of a new corps to be designated the Indian Hospital Corps. This corps will combine, in one organization, the Army Bearer Corps, the Army Hospital Corps and the subordinate personnel of Indian station hospitals.

12. Temporary hospital writers and storekeepers will be engaged on the scales laid down in appendix "D" in which the rates of pay of storekeepers are given These scales are in supersession of those laid down in Army Instruction (India) No. 1231 of 1918. Writers should be paid at the lowest rates on which they can be obtained. Both classes must sign the agreement on I.A.F. Z. 2255, the words "on field service or" in line 12 of the agreement, and "either" and "or out of" in line 13, being deleted in ink and initialled by the officer commanding hospital.

13. All existing regimental hospital followers and menial personnel of followers' hospitals, will, if they are willing, be temporarily transferred, together with their documents, to the Indian station hospital at the station in which they are serving. If not willing to be thus transferred, they will be discharged unless they are pensionable servants, when each individual case will be reported to the Director, Medical Services in India, for orders. The scale on which followers will be employed is laid down in appendix "E." If, in order to complete this scale, it should be necessary to recruit personnel in addition to those transferred from regimental establishments, these should be engaged temporarily at the lowest rates of pay on which they can be obtained. The scale of clothing for all hospital followers (including those now serving) is given in appendix "E."

14. The instructions contained in Army Regulations, India, Volume VI, and Standing Orders for the Military Medical Services, regarding the duties of officers of the Royal Army Medical Corps and assistant surgeons will be generally applicable to officers of the Indian Medical Service and sub-assistant surgeons.

Particular attention must be paid to the detailing of officers and sub-assistant surgeons for medical and sanitary duties, outside hospitals, in connexion with the various units in each station, and for orderly duty.

15. Postage labels will be supplied to officers commanding Indian station hospitals by the Divisional or Brigade Deputy or Assistant Director, Medical Services, in the manner at present in force in the case of British station hospitals. Any funds required will be arranged for by the General Officer Commanding concerned in consultation with the Controller of Military Accounts.

16. Officers commanding Indian station hospitals will exercise the same financial powers as Senior Medical Officers, Indian Medical Service [Army Regulations, India, Volume III, paragraph 6 (*vii*)].

17. The allotments at present made by the Deputy and Assistant Directors, Medical Services, to Senior Medical Officers, Indian Medical Service, to meet contingencies, and for the purchase of articles of local supply, will, in future, be made to officers commanding Indian station hospitals.

18. The pay of officers of the Indian Medical Service, sub-assistant surgeons and hospital establishments will be drawn in accordance with the rules laid down in "Instructions, Staff" for drawing the pay of officers of the Royal Army Medical Corps, assistant surgeons and men of the Army Hospital Corps.

19. Pending the provision of pack stores in Indian station hospitals, Indian soldiers and followers, when admitted to hospital, will have with them only their chevrons, boots, lotahs, and the necessary cleaning materials. All other articles of clothing and equipment will, on the day on which a man is admitted to hospital, be removed and retained under regimental arrangements.

The officer commanding Indian station hospital will furnish the officer commanding unit with the names of all men who are to be discharged from hospital one day prior to their discharge. The officer commanding unit will return the men's clothing to hospital on the morning of the day of discharge.

20. Pending further orders the most suitable arrangements must be made for carrying on the station hospital system in existing permanent or temporary hospital buildings expanded by the provision of such temporary buildings as may be sanctioned on representations made to the Director, Medical Services in India.

21. Indian station hospitals will be dieted institutions, the scales of diet being as authorized in Army Instruction (India) No. 1277 of 1918. The necessary additional furniture and equipment have been sanctioned on a provisional basis in Army Instruction (India) No. 1231 of 1918. Pending the issue of revised scales of medical and surgical equipment, the equipment at present allowed will be continued in use.

22. The necessary amendments to regulations will be issued in due course.

23. Separate orders will be issued later in regard to the incidence of the extra expenditure entailed by these orders and the source from which it should be met.

A. H. BINGLEY, *Major-General*,
Secretary to the Government of India.

[5041 (D. M. S.), D.]

Appendix "*A*" shows the classification of Indian station hospitals. There are 64 in the first class, 13 in the second class, 18 in the third class, 19 in the fourth class, and 34 in the fifth class.

Appendix "*B*" is as follows:

Pay and Allowances of Officers of the Indian Medical Service.

With effect from the 1st December, 1918, the grade pay of officers of the Indian Medical Service in military employment (with the exception of those holding appointments carrying staff pay or consolidated pay, or those for which special rates of pay have been authorized) will be as follows:

	Rs. per mensem.
Lieutenant-Colonel specially selected for increased pay	1,250
Lieutenant-Colonel	1,100
Major, after 3 years' service as Major ...	825
Major	750
Captain, after 10 years' total service ...	700
" " 7 " "	650
" " 5 " "	600
Captain	550
Lieutenant	450

Separate orders will be issued in regard to the emoluments of temporary officers of the Indian Medical Service under the scheme.

2. The above rates of pay represent the total remuneration for duties which officers of the Indian Medical Service (other than those holding appointments which carry staff or consolidated pay or for which special rates of pay have been authorized) may be called on to perform.

The following are also exceptions to this rule:

(*a*) the extra allowances included in Army Regulations, India, Volume I, paragraph 11 (*a*), except that authorized for medical charge of the Cavalry of the Corps of Guides which will be abolished;

(*b*) the specialist allowance authorized in Army Regulations, India, Volume I, paragraph 155 (*d*) (*iv*);

(*c*) the charge allowances referred to in paragraph 5 of this appendix.

3. The allowances for the additional and temporary medical charge of troops and followers, admissible to officers of the Royal Army Medical Corps, and Indian Medical Service, under Army Regulations, India, Volume I, paragraphs 11 (*b*), (*c*) and (*d*) and 117, and also all similar charge allowances for labour corps, etc., will be abolished.

4. The horse allowance at present admissible to officers of the Indian Medical Service in medical charge of Indian cavalry regiments (Army Regulations, India, Volume I, paragraph 264) will be abolished.

5. Charge allowance for officers commanding Indian station hospitals and second-in-command allowance for officers appointed second-in-command of first and second class Indian station hospitals, will be admissible at the following rates in addition to the rates of grade pay shown in paragraph 1 above:

(*a*) *Charge Allowance.*

	Rs. per mensem.
1st class hospitals	240
2nd ,, ...	180
3rd ,, ...	120
4th and 5th class hospitals	*Nil*

(*b*) *Second-in-command Allowance.*

1st class hospitals	120
2nd ,, ...	90

6. Officers, except those holding appointments which carry staff or consolidated pay, will, while on general leave in India, draw grade pay according to the scale given in paragraph 1 of this appendix.

7. The rates of pay and the rules governing the pay (including the pay while on general leave in India) of officers holding appointments which carry staff pay or consolidated pay will remain as at present.

8. If, under the new arrangements, the emoluments of any officer, now serving, fall below the present consolidated pay of an officer of his seniority in charge of a regiment (Army Regulations, India, Volume I, paragraph 11), the case should be submitted for the orders of the Government of India. The term emoluments, as used here, does not include the specialist allowance admissible under Army Regulations, India, Volume I, paragraph 155 (*d*) (*iv*).

Appendix "*C*" relates to the appointment, pay, and promotion of ward orderlies; it allows their employment up to eight men per 100 beds, and they will be chiefly pensioned and discharged soldiers. The pay will be that admissible under existing regulations, but there will be also nursing payment to ward orderlies certified to be proficient in nursing duties, at the rate of 2 rupees a month after one year's service, 4 rupees after five years, and 5 rupees after seven years' service.

Appendix "*D*" lays down the scale of temporary hospital writers and hospital storekeepers authorized for Indian station hospitals.

Appendix "*E*" lays down the scale of hospital followers and their clothing.

AUXILIARY ROYAL ARMY MEDICAL CORPS FUNDS.

THE usual quarterly meeting of the committee was held on January 31st, at 11, Chandos Street, W.1, when Colonel Ewen Maclean (chairman) was in the chair. Grants were made to the widows and orphans of four officers and to the widows and orphans of seven men of the rank and file. Widows or orphans of officers or men of the Auxiliary Royal Army Medical Corps requiring help should apply to the honorary secretary of the Funds at 11, Chandos Street, Cavendish Square, W.1.

THE medical journals of Spain are agitating for the establishment of a ministry of public health. The movement has the support of the leaders of the profession. Professor Ramon y Cajál, however, while strongly in favour of the proposal, points out that there are practical obstacles in the way of its adoption owing to the indifference of the governing classes in regard to hygiene and to economic and administrative difficulties. The distinguished physiologist, who is in his sixty-sixth year, mentions incidentally that the state of his health prevents his taking an active part in the campaign.

Obituary.

WE regret to record the death of DR. WILLIAM GEORGE KEMP of Hastings, which occurred with tragic suddenness in a tramcar on January 24th. His health had been failing for some time, but no immediate apprehension was entertained. Dr. Kemp, who was born at Alnwick in 1846, was educated at King's School, Canterbury, and entered St. Bartholomew's Hospital in 1863. Four years later he took the M.R.C.S.Eng. and L.R.C.P.Lond. He went out to New Zealand the year after, as house-surgeon to the Nelson Hospital, and in 1870 began private practice in Wellington. He was ophthalmic surgeon to the Wellington Hospital, and had a wide consulting general practice. He was the first surgeon to perform ovariotomy in that country, where he was very highly esteemed for his skill and sterling worth. After his return to England in 1892, he took the M.D.Durh., but never practised or took any active part in medical affairs. He had been a member of the British Medical Association for many years. When he went to live at Hastings, ten years ago, he found a large number of friends who honoured and admired him for his high moral character and his charming disposition, which quickly commanded confidence and an affectionate regard. Dr. Kemp married in 1870 Charlotte, daughter of Dr. J. D. Greenwood, who survives him. He had four sons and three daughters. One daughter, a King's College Hospital Sister, was killed by a bomb while working at a Red Cross hospital in Belgium. One son is a major in the New Zealand Medical Corps, another is Captain R.A.M.C., both still in France; a third son is in practice in New Zealand. Dr. Kemp was one of the most loyal and patriotic of men, a staunch churchman, and a real Christian.

DR. SIMON ALEXANDER KUNY, late Captain R.A.M.C., died of influenza at New Somerset Hospital, Capetown, of which he was resident surgeon, on October 17th, 1918. He was the son of Dr. A. J. Kuny of Volksrust, Transvaal, and was educated at Edinburgh University, where he graduated M.B. and Ch.B. in 1915, subsequently taking a temporary commission in the R.A.M.C., in which he served with the British Expeditionary Force.

COLONEL JULES ISHAM ROUTH, A.M.S. (retired), died at Cheltenham on January 13th, aged 66. He was educated at Edinburgh University, and took the M.R.C.S. and L.R.C.P.Ed. in 1876. He entered the army as surgeon in 1878, attained the rank of colonel in 1904, and retired on half-pay in 1906. He served on the North-West frontier of India in the Tirah campaign of 1897–98, previous to which he had been one of the first medical officers employed as a volunteer in plague duty in Bombay when that disease broke out in India in 1896–97.

DR. HAROLD SINCLAIR COGHILL, West African Medical Staff, died at Guildford on January 24th, aged 38. He was the youngest son of the late Dr. J. G. Sinclair Coghill of Ventnor and Edinburgh, and was educated at Edinburgh University, where he graduated M.B. and Ch.B. in 1905. He also took the certificate of the London School of Tropical Medicine in 1908, and the Cambridge diploma in tropical medicine and hygiene in 1911. After acting as senior demonstrator in the London School of Tropical Medicine he joined the W.A.M.S. He served as a member of the Special Commission for the investigation of yellow fever and other non-malarial fever in West Africa in 1913, and recently held the post of assistant in the medical research institute at Lagos.

DR. VINCENZO CERVELLO, a well known Sicilian physician, who died recently, was born in 1854. He succeeded his father in the chair of materia medica at Palermo, and after a time migrated to the University of Catania as professor of the same subject. He returned to Palermo and published many monographs on the action of paraldehyde, iron, and other agents, and founded the *Archivio di Farmacologia e Terapeutica*. He established a sanatorium for tuberculous patients at Palermo and did such good work in combating epidemics and in the promotion of sanitary reform that the Italian Government awarded him a gold medal.

CAPTAIN ERNEST ALBERT WILLIAM HENLEY, New Zealand Medical Corps, died at Napier, New Zealand, on November 14th, 1918. He was the eldest and last surviving son of Mr. J. W. Henley of Shankill, co. Dublin, his brothers, Second Lieutenants F. L. Henley, Sherwood Foresters, and H. T. Henley, Royal Irish Rifles, having been killed in action in France in 1916 and 1917 respectively. He was educated at Trinity College, Dublin, where he graduated B.A. in 1898, M.B., B.Ch., and B.A.O. in 1901, and M.D. in 1911. At the university he gained a medical scholarship and the gold medal in physical science, also taking the gold medal for operative surgery at the Royal College of Surgeons, Ireland, and the Hudson scholarship at the Adelaide Hospital, Dublin, where he afterwards served as house-surgeon. In 1900 he went to New Zealand, where he settled in practice at Napier, and was for fourteen years secretary to the Hawkes Bay Branch of the British Medical Association. At the beginning of the war he joined the New Zealand Medical Corps, but was not sent on foreign service for health reasons.

Universities and Colleges.

UNIVERSITY OF CAMBRIDGE.

THE following medical degrees were conferred at a congregation held on January 31st:

M.D.—S. G. Askey, A. G. Shera.
M.B.—W. T. Warwick.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

AN ordinary Comitia of the Royal College of Physicians of London was held on January 30th, when Dr. Norman Moore, the President, was in the chair.

The following were admitted Members of the College:

C. T. Champion de Crespigny, M.D.Melb., W. H. Grace, M.B.Lond., L.R.C.P., N. F. Hallowes, M.B.Oxon., G. R. Pirie, M.B.Toronto, L.R.C.P., W. G. Porter, M.D.Brussels, L.R.C.P., A. F. Rook, L.R.C.P., T. W. Wadsworth, M.D.Liverpool.

Licences to practise physic were granted to sixty-four candidates who had passed the required examinations and had conformed to the by-laws and regulations

Diplomas in public health were granted to the following candidates:

G. A. Birnie, M.B., Ch.B.Melb., J. A. Drake, M.B., B.S.Lond., L.R.C.P., M.R.C.S., T. H. Jamieson, M.D.Edin., A. D. Logandan, L.R.C.P., M.R.C.S., K. M. B. Simon, M.B.Toronto, L.C.P.and S. Ontario, P. Smith, M.D.Lond., L.R.C.P., M.R.C.S., J. Wotherspoon, M.D., Ch.B.Glasg.

The following were elected councillors on the nomination of the council:—Dr. Davy vice Dr. Guthrie, deceased; Drs. Head, Carr, Still, and Craig, vice Drs. Wethered, James Calvert, Sir James Galloway, and Dr. Ogle, who retire by rotation. Sir Francis Champneys was elected a representative on the Central Midwives Board, and Dr. Sidney Martin a representative on the senate of the University of London, vice Sir Frederick Taylor, resigned. An address was received from the Royal College of Physicians of Ireland on the occasion of the quatercentenary of the college. A gold Browne medal was received from Dr. Crawfurd.

The President announced that he had appointed Dr. Crawfurd to be Harveian orator and Dr. Beddard to be Bradshaw lecturer in 1919, and that the council had appointed Dr. Aldo Castellani to be Milroy lecturer in 1920. Dr. Topley will give the Goulstonian lectures on the spread of bacterial infection, and Sir Humphry Rolleston the Lumleian lectures on cerebro-spinal fever.

The following report was received from the Committee of Management:

The Committee recommend that the courses of instruction in pathology, practical pathology, and bacteriology at the University of Cape Town be accepted as fulfilling the requirements of the Regulations, Section II, par. XXI (*d*) and (*h*), 4, 5, 6, and 8.

The Committee of Management received applications from the National Hospital for Epilepsy and Paralysis, Queen Square, and from the Hospital for Sick Children, Great Ormond Street, for recognition as teaching institutions for students in clinical medicine, and for part of the medical clerkship and surgical dressership. Both these hospitals are already recognized as teaching institutions by the Universities of Oxford, Cambridge, London, and Durham.

The Committee of Management felt that it would be highly undesirable for any considerable amount of the time spent on clinical instruction and in holding appointments in special hospitals to take the place of the period required in a general hospital, but offered no objection to a period, not exceeding two months in all, for clerking and dressing being spent at these two hospitals or other special hospitals which might hereafter be recognized by the Committee of Management. With regard to an application by the Dean of University College Hospital Medical School to utilize this concession, the Committee of Management assumed that the National Hospital and the Hospital for Sick Children would allow students from other medical schools than University College to go there in exactly the same way should the Deans of their schools desire to send them.

The Committee granted an application from the London School of Medicine for Women that students may be allowed to complete their gynaecological clerkships in the Elizabeth Garrett Anderson Hospital, in which 50 per cent. of the surgical cases are gynaecological.

Medical News.

THE annual meeting of the Medical Sickness, Annuity, and Life Assurance Friendly Society will be held at the offices of the society, 300, High Holborn, W.C., on Tuesday, March 25th, at 4 p.m.

MR. R. J. PYE-SMITH, consulting surgeon to the Sheffield Royal Hospital, and Emeritus Professor of Surgery in the University of Sheffield, which he has represented on the General Medical Council since 1911, is about to retire from practice, with the intention of residing in the south of England.

AN announcement is made in our advertising pages this week of a special "reconstruction" clinical course, in general medicine and surgery and all special departments, to be given at the West London Post-Graduate College from February 17th to April 11th.

THE fifth edition of Gould's *Elements of Surgical Diagnosis* is in the press. It has been revised by Sir Alfred Pearce Gould and Mr. Eric Pearce Gould, and much new matter introduced without, however, adding to the bulk of the volume.

THE first of the social meetings arranged by the Royal Society of Medicine for the reception of medical officers of the Navy, R.A.M.C., R.A.F., and the Overseas contingents and of the United States and Allies was held on Wednesday last, when Sir John Bland-Sutton gave a short address on gizzards and counterfeit gizzards. On Wednesday evening next Sir Arbuthnot Lane will speak on some aspects of stasis.

THE Lettsomian Lectures before the Medical Society of London will be delivered on March 10th, 17th, and 24th, at 9 p.m., by Colonel W. H. Willcox, C.B., C.M.G., M.D., whose subject will be jaundice. The annual oration will be delivered by Sir John Tweedy, F.R.C.S., on May 12th, at 9 p.m.

THE Child-Study Society has arranged a course of lectures to be given at the Royal Sanitary Institute, 90, Buckingham Palace Road, at 6 p.m. on alternate Thursdays, beginning on Thursday next, when Dr. C. W. Kimmins will speak on the significance of children's dreams.

THE municipal authorities of Milan recently accepted the offer of gratuitous vaccination against influenza made by Professor Serafino Belfanti, Director of the Institute of Serumtherapy. The Assessor of Hygiene, Dr. Luigi Veratti, at once placed the department of antityphoid inoculation in the health bureau at his disposal for the purpose, and within a few days more than a thousand persons were vaccinated.

SIR L. WORTHINGTON EVANS, Minister of Pensions, has appointed an "Officers' Friend," attached to the department, whose duty will be to give information to officers and officers' widows as to the retired pay, pensions, and allowances to which they are entitled under the Pay Warrant and the various pensions warrants. This official will attend daily at the Ministry of Pensions, Westminster House, 7, Millbank, London, S.W.1, and inquiries may be addressed to him there, either personally or by letter.

A Hunterian lecture on the action of chemical and physiological antiseptics in septic wounds will be given at the Royal College of Surgeons of England on February 12th by Mr. Alexander Fleming, F.R.C.S., assistant lecturer in bacteriology at St. Mary's Hospital Medical School. A Hunterian lecture on the early treatment of compound fractures and other severe injuries of the upper limb will be given by Mr. E. G. Slesinger, M.B., F.R.C.S., on February 17th. Two Arris and Gale lectures will be delivered, the one on February 19th by Mr. Edred M. Corner, surgeon to St. Thomas's Hospital, on the nature of scar tissue and painful amputation stumps; and the other on February 21st by Lieut.-Colonel E. M. Cowell, D.S.O., F.R.C.S., medical officer to Croydon General Hospital, on the initiation of wound shock and its relation to surgical shock. The lectures will be given at the college at 5 p.m. on each day.

Letters, Notes, and Answers.

In order to avoid delay, it is particularly requested that ALL letters on the editorial business of the JOURNAL be addressed to the Editor at the Office of the JOURNAL.

The postal address of the BRITISH MEDICAL ASSOCIATION and BRITISH MEDICAL JOURNAL is 429, Strand, London, W.C.2. The telegraphic addresses are:

1. EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology, Westrand, London*; telephone, 2631, Gerrard.
2. FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate, Westrand, London*; telephone, 2630, Gerrard.
3. MEDICAL SECRETARY, *Medisecra, Westrand, London*; telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin.

The address of the Central Medical War Committee for England and Wales is 429, Strand, London, W.C.2; that of the Reference Committee of the Royal Colleges in London is the Examination Hall, 8, Queen Square, Bloomsbury, W.C.1; and that of the Scottish Medical Service Emergency Committee is Royal College of Physicians, Edinburgh.

LETTERS, NOTES, ETC.

THE TREATMENT OF WAR PSYCHONEUROSES.

CAPTAIN E. PRIDEAUX, R.A.M.C.(T.), Ewell War Hospital, writes: In my memorandum under this heading (January 11th) I joined issue with Dr. Middlemiss on a question of fact only. He asked, "Do we, as a matter of fact, find that the patients are unable to recall the emotional disturbance which has led up to the present disorder?" I stated that my results had convinced me that forgotten experiences are the rule in psychoneurotic patients, and that Dr. Middlemiss was not justified in answering this question in the negative without analysing cases from this point of view. In his memorandum (February 1st) he asks from what additional symptoms the cases quoted suffered, and if these also were to be referred to a forgotten incident, either the one quoted or some not identified. The patients suffered from general symptoms of anxiety neurosis with depression, and these symptoms disappeared after revival of all their war experiences as soon as they were able to talk about them without emotion, but I could not say to what particular incidents the symptoms were due. I would refer Dr. Middlemiss to his letter of December 21st, 1918, in which he states, "Where the all-pervading sense of depression is present argument, persuasion, and counter suggestion are usually futile," and ask him what form of treatment is available for the other observers "equally successful in their results, and this without invoking the particular agency he favours, and, indeed, in many cases by working on apparently diametrically opposite lines"?

INCREASED GRANTS TO INSURANCE PRACTITIONERS.

CORVUS writes: Some thousands of panel practitioners have recently made application to the Insurance Commissioners for the war bonus recently granted. That bonus is by no means satisfactory, either in amount or in the principle of its distribution, as a recognition of increased work performed under conditions implying an actual diminution in the value of most of our practices. Still it is a tangible recognition of the justice of the claim for some increase in remuneration which we have been urging for so long.

I desire to point out that the obtaining of this grant is due, in the main, to the action, persistent and consistent, of the Insurance Acts Committee of the British Medical Association, acting after considering representations made to them by various Panel Committees. There is no other body or society of medical men which could have done so much for the panel practitioner. Yet, while all of these latter will participate in the grant (for I do not suppose any of them will decline to do so), a very large percentage are not members of the Association. If they realize that the bonus they are about to receive is the result of the pressure put upon the Commissioners by the British Medical Association through its Insurance Acts Committee, surely they might at least contribute £2 2s. each and become members of the Association. I wish to suggest this course particularly to members of the Medico-Political Union.

The British Medical Association is not yet a perfect body in any way. Seeing that none of its members are such, it would be too much to expect. But it can, must, and will be improved. Much has been done. More remains to be done. But it must be done by us, its members, not by outsiders. Reform must come from within, not from without. Let the disappointed and discontented non-members join up and lend a hand in the process of renovation and reconstruction, or else let them remain outside and hold their peace.

A PART-TIME STATE MEDICAL SERVICE.

WE have received from Dr. H. E. C. Keith Murray (Burley, Hants) a pamphlet written by him with the title, *A Ministry of Health, embodying a Part-time State Medical Service and State Insurance Scheme*. He regards it as highly improbable that any whole-time State medical service will be introduced at present, or in the near future, owing to its unpopularity with the majority of the medical profession and the lack of support the suggestion has received from the public generally, and the Labour Party and the friendly societies in particular. He, therefore, puts forward in brief outline a suggested scheme under which the medical personnel of the service would consist of both whole-time and part-time officers. The former would include the members of hospital and other staffs, district consultants, referees, and public health medical officers (such posts being as far as possible filled by demobilized R.A.M.C. men without practices). The part-time medical personnel would consist of general practitioners.

Dr. Keith Murray proposes that the whole-time staffs should receive salaries ranging from £100 to £2,000 a year, in some cases with board or travelling allowances—for instance, house surgeons and travelling consultants. For the part-time staff of general practitioners who would be grouped in panels, he considers a capitation fee of 10s. a year preferable to a system of payment for attendance. The midwifery fee, he suggests, should range between two and five guineas. Dispensing by doctors, where this is unavoidable, should be paid at the annual rate of 2s. 6d. a head. There should be a mileage fee of 1s. each way for every mile over two miles. Anaesthetics, autopsies, operations, etc., should command a special fee of from one to five guineas.

Dr. Keith Murray's skeleton scheme contemplates provision for State dental and nursing services, the endowment of medical research, the absorption of the whole insurance organization by the State, and the State ownership and administration of hospitals, dispensaries, sanatoriums, asylums, and infirmaries. Lastly, he has a vision of a comprehensive future medical service open to all, with free medical education, competitive entrance examinations, choice of service (civil or military), a system of promotion by (*a*) examination, and (*b*) service, and the provision of pensions.

MORTALITY AMONG AMERICAN DOCTORS IN 1918.

DURING 1918 the deaths of 2,616 medical practitioners in the United States and Canada were recorded in the *Journal of the American Medical Association*. On an estimate of a total number of 155,000 practitioners this is equivalent to an annual death-rate of 16.88 per 1,000. The average mortality for the period of sixteen years 1902 to 1918, inclusive, was 15.61 per 1,000. Of the deceased, 474 were between 51 and 60 years of age, 463 between 61 and 70, 358 between 71 and 80, 160 between 81 and 90, and 18 between 91 and 100. Twenty-one deaths were due to general diseases, 261 to diseases of the nervous system, 331 to diseases of the respiratory system, 98 to diseases of the digestive organs, 134 to diseases of the genito-urinary apparatus, 318 to senility, 39 to suicide, 89 to accident, 15 to homicide, and 69 followed surgical operations. In the period from 1902 to 1917, inclusive, the percentage of deaths from pneumonia in the total mortality varied from 5.62, the lowest point, in 1914 to 9.47, the highest, in 1916. In the first nine months of 1918 the percentage was 12.5. The number of deaths from pneumonia and influenza in the last three months of the year brought the percentage of deaths from these diseases in 1918 up to 30.69, an unprecedented mortality. Of the 89 accidental deaths, 24 were caused by automobile, 16 by automobile-railway (grade crossings), 10 by falls, 8 by railway, 4 by poison, 3 each by fires, drowning, sunstroke, and unclassified; 2 each by burns, injuries inflicted by animals, and explosion; 1 each by Roentgen-ray burns, poisonous gases, fracture, freezing, lightning, starvation, firearms, injuries in mines, crushing, and asphyxia. The modes of suicide were by firearms, 20; by poison and cutting instruments, each 6; by strangulation, 3; by asphyxia, drowning, jumping from high places, and unclassified, each 1. Of the deceased doctors, 2 had been members of Congress, 1 an ambassador, 2 consuls, 4 members of State Senates, 24 members of the lower houses of legislature, and 33 mayors.

THE JAPANESE FLY-TRAP.

IN the JOURNAL of January 5th, 1918, Captain N. S. Gilchrist described an ingenious apparatus known as the Japanese fly-trap. We have had many inquiries from readers as to where this can be procured in England, and have referred the question to Captain Gilchrist, who replies from Alexandria that the fly-trap is not, so far as he is aware, at present on the general market in Europe. Those in use in Egypt were sent from Japan as a present to the military medical authorities for trial. The apparatus is believed to be now on sale in India, and as soon as shipping is available it should be procurable in England also. Captain Gilchrist adds that it has been copied by skilled workmen in the army, but so far not with much success.

THE appointment of certifying surgeon for Wolston (Warwick) is vacant.

SCALE OF CHARGES FOR ADVERTISEMENTS IN THE BRITISH MEDICAL JOURNAL.

	£	s.	d.
Seven lines and under	0	6	0
Each additional line	0	0	9
Whole single column	4	0	0
Whole page	12	0	0

An average line contains six words.

All remittances by Post Office Orders must be made payable to the British Medical Association at the General Post Office, London. No responsibility will be accepted for any such remittance not so safeguarded.

Advertisements should be delivered, addressed to the Manager, 429, Strand, London, not later than the first post on Wednesday morning preceding publication, and, if not paid for at the time, should be accompanied by a reference.

NOTE.—It is against the rules of the Post Office to receive *poste restante* letters addressed either in initials or numbers.